

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 01721 439

1. PLACE OF DEATH:

County Prince George'sCity or town Randall
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 1 week

Hospital, institution, or street address where death occurred:

Marion HospitalHow long in hospital or institution? 1 week

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County HowardCity or town Clarksville
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION) ✓

2.(a) If veteran, name war _____

3. (a) FULL NAME

Edwin Osborne Adams

3. (b) Social Security Number

4. Sex Male5. Color or race White6. (a) Single, married, widowed, or divorced Widowed6. (b) Name of husband or wife Rebecca Clark7. Birth date of deceased (mo., day, yr.) Jan 8/71

8. (c) If alive, give age _____ years

8. AGE: Years 45 Months _____ Days 23 It less than one day _____ hrs. _____ min.9. Birthplace Gondus N.Y.
(Town, county, and state)10. Usual occupation Farmer11. Industry or business Own farm12. Name Andrew N. Adams13. Birthplace Shenandoah Eng.14. Maiden name Mary Sargent15. Birthplace Shenandoah Eng.16. Informant John Clark AdamsAddress Clarksville, Md.17. Burial, cremation, or removal. When? Feb 3-1946

(Burial, cremation, or removal) When? _____ (month) (day) (year)

Cemetery or crematory St. MarksLocation Highland Md18. Funeral director F. C. NequithomAddress Ellicott City Md19. Feb 13 19 46 M. Busch

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 1 19 46 at 6:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19 42 to Feb 1 19 46and that I last saw him alive on Feb 1 19 46Immediate cause of death Labor PneumoniaDURATION 10 daysDue to Infection

Due to _____

Other conditions Arteriosclerosis

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE J. M. Warrup M.D.Address Fourch, Md.Date signed 2/1/46

M. D. or other _____

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FEB 5 1946
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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 132

CERTIFICATE OF DEATH

01772

Reg. Dist. No. 237

1. PLACE OF DEATH:

County Prince George's
City or town Aquasco
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 50 years
Hospital, institution, or street address where death occurred:
Aquasco Road
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Prince George's
City or town Aquasco
(If outside city or town limits, write RURAL and give nearest town)
Street No. Aquasco Road
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

Carrie Lee Banks

3. (b) Social Security Number

4. Sex Female 5. Color or race Colored 6.(a) Single, married, widowed, or divorced Widowed
6.(b) Name of husband or wife Colbert Banks

7. Birth date of deceased (mo., day, yr.) March 27, 1884 6.(c) If alive, give age _____ years

8. AGE: Years 61 Months 10 Days 29 If less than one day _____ hrs. _____ min.

9. Birthplace Aquasco, Md.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Own Home

FATHER 12. Name Henry Gross

13. Birthplace Maryland

MOTHER 14. Maiden name Charity Chapman

15. Birthplace Maryland

16. Informant Colbert Lee Banks

Address Aquasco, Md.

17. Burial (Burial, cremation, or removal) Burial Date thereof 2/21/46
(month) (day) (year)

Cemetery or crematory John Wesley M.E.

Location Aquasco, Md.

18. Funeral director Hunt & Ryan

Address Woodrow, Md.

19. Feb 20 19 46 Mrs. H. B. Carter
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 18 19 46 at 4:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from _____ 19_____, to _____ 19_____, and that I last saw h. _____ alive on _____ 19_____.

Immediate cause of death acute congestive heart failure

Due to Cardiovascular renal disease

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Antopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Forestall M.D. or other _____

Address Forestall Date signed 2-18-46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BY AIR TO THE SECRETARY OF THE ARMY

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FEB 22 1946

BUREAU V S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *3d*

CERTIFICATE OF DEATH

01773

Reg. Dist. No.

239

1. PLACE OF DEATH:

County *Prince Geo*
City or town *Laurel*
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? *18 yrs*
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State *Maryland* County *Prince Geo*
City or town *Laurel*
(If outside city or town limits, write RURAL and give nearest town)
Street No. *P.F.D.*
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

WILLIAM T. BARTON

3. (b) Social Security Number

4. Sex *Male* 5. Color or race *white* 6.(a) Single, married, widowed, or divorced *widowed*
6.(b) Name of husband or wife *Barbara Barton*
7. Birth date of deceased (mo., day, yr.) *Feb 23 - 1854* 6.(c) If alive, give age _____ years
8. AGE: Years *91* Months *11* Days *29* If less than one day _____ hrs. _____ min.

9. Birthplace *Maryland*
(Town, county, and state)
10. Usual occupation *retired*
11. Industry or business *William Barton*

MOTHER FATHER
12. Name *William Barton*
13. Birth *MD*
14. Maiden name *Margaret Hathaway*
15. Birthplace *MD*
16. Informant *Harry Barton*
Address *Laurel MD*
17. (Burial, cremation, or removal, which?) *Burial* Date thereof *Feb 25-46*
(month) (day) (year)
Cemetery or crematory *Louisa Park*
Location *Baltimore MD*
18. Funeral director *Lloyd Lauer*
Address *Laurel MD*
19. *February 25 - 46* *Car E. Wachter*
(Date rec'd by registrar) (Signature) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH *Feb 21 1946* at *11:30* M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *Feb 18 1946* to *Feb 21 1946*
and that I last saw him alive on *Feb 20 1946*
Immediate cause of death *Myocarditis* DURATION *2 yrs*
Arteriosclerosis *10 yrs*
Due to
Due to
Other conditions *Senile Dementia* *2 yrs*
(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE *J. M. Marston MD*
Address *Laurel* Date signed *2/23/46*
M. D. or other

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FEB 28 1946
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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

92-6

CERTIFICATE OF DEATH

01774 242
Reg. Dist. No.

1. PLACE OF DEATH:

County Prince Georges
City or town Brightseat
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 25 Years
Hospital, institution, or street address where death occurred:
Landover Maryland RFD #1
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Pr Georges
City or town Brightseat
(If outside city or town limits, write RURAL and give nearest town)
Street No. Landover Maryland RFD #1
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

Margaret Ella Beane

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Married
6.(b) Name of husband or wife John Owen Beane
6.(c) If alive, give age 63 years
7. Birth date of deceased (mo., day, yr.) December 3 1886
8. AGE: Years 59 Months 2 Days 23 If less than one day
.....hrs.min.

9. Birthplace Mellwood Pr Geo Co Maryland
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Own home

12. Name Frederick Binger

13. Birthplace Germany.

14. Maiden name Christiana Deewall

15. Birthplace Pennsylvania

16. Informant John Owen Beane

Address Landover Md RFD #1

17. Burial Date thereof Mar. 1-46
(Burial, cremation, or removal, which?) (month) (day) (year)

Cemetery or crematory Wm Lincoln

Location Bladensburg, Md.

18. Funeral director Elchiel Brothers

Address Upper Marlboro, Md.

19. 2-28-46 19 46 Irene A. Bonner
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 26 19 46 at 10:20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
February 12 19 46 to February 26 19 46
and that I last saw her alive on February 25 19 46

Immediate cause of death Cardiac Decompensation DURATION 13 days

Due to Chronic Valvular Heart disease (Mitral Regurgitation) 5 Years History

Due to

Other conditions

(Include pregnancy within 2 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE W. S. Pittie M.D.

6906 Ritchie Road SE M. D. or other

Address Washington 19, D.C. Date signed Feb 26, 1946

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MAR 18 1946
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH:

County Prince George's
 City or town (rural) Glenn Dale, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 1 mo., 6 days
 Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
 How long in hospital or institution? 1 mo., 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State D. C. County _____
 City or town Washington
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 829 - 20th St. N. W.
 (If rural, give LOCATION)
 2.(a) If veteran, name war. _____

3. (a) FULL NAME

Joseph Booker

3. (b) Social Security Number

578-36-6951

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Single
 6. (b) Name of husband or wife _____
 7. Birth date of deceased (mo., day, yr.) December 22, 1892 5. (c) If alive, give age _____ years
 8. AGE: Years 53 Months 1 Days 29 If less than one day _____ hrs. _____ min.

9. Birthplace Durham, North Carolina
 (Town, county, and state)
 10. Usual occupation Govt. Clerk
 11. Industry or business _____

FATHER 12. Name Thomas W. Booker
 13. Birthplace Durham, North Carolina
 MOTHER 14. Maiden name Annie Reeves
 15. Birthplace Richmond, Virginia

16. Informant Decedent
 Address _____
 17. Removal to Date thereof Feb. 21, 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory _____
 Location Washington, D. C.
 18. Funeral director W. W. Phillips
 Address 1400 - Chapin St. N. W.

19. Feb. 20 19 46 Rowland S. Phillips
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 20 19 46 at 8:03 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Jan. 14 19 46 to Feb. 20 19 46
 and that I last saw him alive on Feb. 20, 1 19 46

Immediate cause of death Pulmonary tuberculosis DURATION 2 months

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Daniel Leo Piniscane, M.D. M. D. or other _____Address Glenn Dale, Md. Date signed 2/20/46

RECEIVED
MAR 1 1946
BUREAU OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13-

CERTIFICATE OF DEATH

01776

Reg. Dist. No. 243

1. PLACE OF DEATH:

County Prince George's
City or town (rural) Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 mo., 18 days
Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
How long in hospital or institution? 1 mo., 18 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State D. C. County _____
City or town Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1812 You Place S. E.
(If rural, give LOCATION)
2(a) If veteran, name war _____

3. (a) FULL NAME

BERNARD S. BOSWELL

3. (b) Social Security Number

579-05-4052

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed
6. (b) Name of husband or wife Olive Boswell (Dec.)
6. (c) If alive, give age _____ years
7. Birth date of deceased (mo., day, yr.) September 19, 1901
8. AGE: Years 44 Months 4 Days 27 If less than one day _____ hrs. _____ min.

9. Birthplace Oxen Hill, Maryland
(Town, county, and state)
10. Usual occupation Paper Hanger
11. Industry or business _____
12. Name Maynard Boswell
13. Birthplace Maryland
14. Maiden name Hester Strother
15. Birthplace Virginia

16. Informant Decedent
Address _____
17. Removal Date thereof Feb. 15, '46
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Ra Blata, Ind.
Location _____
18. Funeral director W. W. Chambers & Co.
Address 577 11th St. S.E.
19. Feb. 15, 1946 Rowland S. Phillips
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 15, 1946 at 11:30 A. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 28, 1945 to Feb. 15, 1946
and that I last saw him alive on Feb. 15, 1946

Immediate cause of death Pulmonary Tuberculosis DURATION 2 yrs 2 mo.
Due to _____
Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____
Autopsy results _____
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide _____ Date of _____
Where did injury occur? _____ (City or town) _____ (County) _____ (State)
Injured at home, farm, industry, public place (where?) _____
Means of injury _____ Injured at work? _____
23. SIGNATURE Daniel Leo Pinucane M.D. M. D. or other _____
Address Glenn Dale, Md. Date signed 2/15/46

MARGIN RESERVED FOR BINDING

VS A15

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01777

Reg. Dist. No. 245

1. PLACE OF DEATH:

County Prince George's

City or town Brentwood

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

3715- Rhode Island Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince George's

City or town Brentwood

(If outside city or town limits, write RURAL and give nearest town)

Street No. 3715 Rhode Island Ave

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Katherine M. Boyle

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

7. Birth date of

deceased (mo., day, yr.)

Sept 22, 1866

8. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

79

4

23

hrs.

min.

9. Birthplace

Maryland

(Town, county, and state)

10. Usual occupation

Clerk

11. Industry or business

Retired

FATHER

12. Name

John Boyle

MOTHER

13. Birthplace

Scotland

14. Maiden name

Mary Morrison

15. Birthplace

Scotland

16. Informant

Margaret A. Boyle

Address

218 Second St N.E.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

Jan 18, 1946

(month) (day) (year)

Cemetery or crematory

Rock Creek

Location

Washington D.C.

18. Funeral director

J. E. Smith & Sons

Address

Hyattsville Md.

19. Date rec'd by registrar

July 18, 1946

19

John Serry

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 15, 1946 at 11:46 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19 to 19

and that I last saw him alive on 19

Immediate cause of death

Acute congestive heart failure
Cardiovascular
renal disease

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

Deputy Medical Examiner

23. SIGNATURE

J. E. Smith

M.D. or other

Address. Westville, N.C. Date signed. 2-17-46

MASSACHUSETTS STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

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FEB 20 1946

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 190

CERTIFICATE OF DEATH

01778

Reg. Dist. No. 231

1. PLACE OF DEATH:

County Prince George'sCity or town Glenarden
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 1 month

Hospital, institution, or street address where death occurred:

In a woods just off Lincoln Rd.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince George'sCity or town Admire
(If outside city or town limits, write RURAL and give nearest town)Street No. Admire Road
(If rural, give LOCATION)2.(a) If veteran, name war World War I

3. (a) FULL NAME

John Floyd Brown

3. (b) Social Security Number

4. Sex

male

5. Color or race

Colored

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

June 16, 1895

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

50726

hrs.

min.

9. Birthplace

Annapolis, Md.
(Town, county, and state)

10. Usual occupation

Caretaker

11. Industry or business

Griggsby estate

FATHER

12. Name

Richard C. Brown

13. Birthplace

Virginia

MOTHER

14. Maiden name

Margaret Butler

15. Birthplace

Annapolis Md.

16. Informant

Richard W. Brown

Address

Admire Park Md.

17. Burial

(Burial, cremation, or removal, which?)

Date thereof

Feb 14, 1946
(month) (day) (year)

Cemetery or crematory

Arlington Cemetery
Virginia

Location

F. Griggsby Sons

18. Funeral director

Staten Island Md.

Address

2/13 46 Amanda Dumes
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 11 1946 at 8:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

.....19..... to.....19.....

and that I last saw h..... alive on.....19.....

Immediate cause of death

Shock

DURATION

Due to

Exposure to cold

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

.....Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 2-11-46Where did injury occur? Glen Arden Pk (City or town) Prince George's (County) Md (State)Injured at home, farm, industry, public place (where?) In a woodsMeans of injury Fallout in cold and snowNeurological medical Examiner23. SIGNATURE James T. Bond M. D. or otherAddress Forestville Md Date signed 2-11-46

FEB 16 1946

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 73d

CERTIFICATE OF DEATH

Reg. Dist. No. 234

1. PLACE OF DEATH:

County Prince GeorgesCity or town Clinton Md
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 25 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Pr GeorgesCity or town Clinton Md
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Philip A. Buckler

3. (b) Social Security Number

4. Sex Male5. Color or race white6.(a) Single, married, widowed, or divorced Widowed6.(b) Name of husband or wife Delphine Buckler7. Birth date of deceased (mo., day, yr.) 1/888

6.(c) If alive, give age _____ years

8. AGE: Years 65 yrs 9 Months 9 Days 9 If less than one day _____ hrs. _____ min.9. Birthplace Prince Georges Md. Charles Co
(Town, county, and state)10. Usual occupation Farmer

11. Industry or business

12. Name William B. Buckler13. Birthplace Charles Co. Md14. Maiden name Mal W. Buckler

15. Birthplace _____

16. Informant Joseph A. BucklerAddress Clinton Md17. Burial Date thereof Feb 6 - 1946
(Burial, cremation, or removal, Which) (month) (day) (year)Cemetery or crematory St. John's Catholic Ch.Location Clinton Maryland18. Funeral director Thomas F. MurrayAddress 2007 - Nichols ave SE. Wash DC19. Feb 4 19 46 Howard J. Buckler
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 4th 46 at 7 A. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 3 46 to Feb 4 46 and that I last saw him alive on Feb 3 - 46

Immediate cause of death _____

Arterio Sclerosis 5 yrsChronic Myocarditis 2 yrsDue to Arterio Sclerosis 5 yrs

Due to _____

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide. _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE John E. Bowers M.D. M. D. or otherAddress Prandywood Date signed 3/4/46

RECEIVED

MAR 5 1946

BUREAU V.E.

Evidence for change of age
of deceased is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 942

01779

CERTIFICATE OF DEATH

Reg. Dist. No. 242

FILM No. I O 1 MAR 28 1946

1. PLACE OF DEATH:

County Prince Georges
City or town Fairmont Heights
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 17 yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Md County Prince Georges
City or town Fairmont Heights
(If outside city or town limits, write RURAL and give nearest town)
Street No. 601-60th Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war.

3. (a) FULL NAME

Georgianna Butler

3. (b) Social Security Number

4. Sex Female
5. Color or race Colored
6. (a) Single, married, widowed, or divorced Widowed
6. (b) Name of husband or wife Sumner Butler
6. (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Mar. 27 1886
8. AGE: Years 60 Months 59 Days hrs. min.

9. Birthplace Charles Co. Md.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name unknown

13. Birthplace Charles Md.

14. Maiden name unknown

15. Birthplace unknown

16. Informant Edith Butler

Address 601-60th Ave, Fairmont Heights

17. Burial Date thereof March 2, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Mt. Olivet Cemetery

Location Washington, D.C.

18. Funeral director J. P. Johnson

Address Annapolis, Md.

19. 3/21 1946 F.W. Widrich
(Date rec'd by registrar) (M.D.) State Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 28 1946 at 7:56 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 25 1946 to Feb 28 1946
and that I last saw him alive on Feb 27 1946

Immediate cause of death Acute Cardiac Dilatation
DURATION 7
Due to Coronary Occlusion 1 month
Due to Generalized Atherosclerosis ?
W.H. Moody, M.D.
Other conditions Essential Hypertension
(Include pregnancy within 3 months of death)

Major findings of operations.

Date of op.

Autopsy results.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

Robert R. Nelson, M.D.

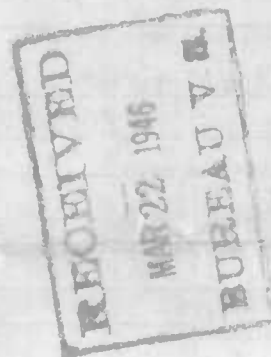
23. SIGNATURE M. D. or other

Address 4112 Grant PL. AVE Date signed 2/28/46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



copy sent to Co. H.O. 3/22/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 92-2

CERTIFICATE OF DEATH

Reg. Dist. No. 0178245

1. PLACE OF DEATH:

County Prince
 City or town North Brentwood
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? twelve years
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County Pri
 City or town North Brentwood
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 8926 Allison St.
 (If rural, give LOCATION)

2.(a) If veteran, name war.

3. (a) FULL NAME

John William Butler

3. (b) Social Security Number

4. Sex

Male

5. Color or race

Colored

6.(a) Single, married, widowed, or divorced

widower

8.(b) Name of husband or wife

Francis Reene

7. Birth date of deceased (mo., day, yr.)

6.(c) If alive, give age years

1866

8. AGE:

Years

Months

Days

If less than one day

80

hrs. min.

8. Birthplace

West Va.

(Town, county, and state)

10. Usual occupation

Retiree

11. Industry or business

Govt

FATHER

12. Name

W. S. Hudson

13. Birthplace

W. Va.

MOTHER

14. Maiden name

W. S. Hudson

15. Birthplace

W. Va.

18. Informant

Mr. Helen Harris

Address

3926 Allison St.

17. Removal

(Burial, cremation, or removal. Which?)

Date thereof

2-55-46

(month) (day) (year)

Cemetery or crematory

Woodlawn Ave

Location

Washington, D.C.

18. Funeral director

Address

John T. Stewart3926 Allison St.

19.

(Date rec'd by registrar)

Feb 1546James Sevier

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Feb 1546

at

5:35 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov1945

to

Feb 151946

and that I last saw him alive on

Feb 111946

Immediate cause of death

Heart failure

DURATION

46 mo

Due to

Valvular Heart disease

Due to

Other conditions

anemia, senile

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

W. S. Hudson, M.D.

M. D. or other

Address

Laurel mdDate signed 2-15-46

RECEIVED
FEB 18 1946
BUREAU OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH:

County Prince George's
 City or town (rural) Glenn Dale, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 26 days
 Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
 How long in hospital or institution? 26 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State D. C. County _____
 City or town Washington
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 756 Hobart Place N. W.
 (If rural, give LOCATION)
 2. (a) If veteran, name war _____

3. (a) FULL NAME

John D. Byrd

3. (b) Social Security Number

577-03-3486

4. Sex Male 5. Color or race Colored 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Demeatry Byrd
 6. (c) If alive, give age 50 years
 7. Birth date of deceased (mo., day, yr.) September 7, 1889
 8. AGE: Years 56 Months 5 Days 10 If less than one day _____ hrs. _____ min.

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 17, 1946 at 10:10 A.M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 22, 1946 to Feb. 17, 1946
 and that I last saw him alive on Feb. 17, 1946

Immediate cause of death Pulmonary tuberculosis DURATION 26 days

9. Birthplace Richmond, Virginia
 (Town, county, and state)
 10. Usual occupation Delivery man for
Trew Motor Company
 11. Industry or business _____
 12. Name Daniel Byrd
 13. Birthplace Virginia
 14. Maiden name ?
 15. Birthplace Virginia

Due to _____
 Due to _____
 Other conditions _____
 (Include pregnancy within 8 months of death)

16. Informant Decedent
 Address _____
 17. Removal Date thereof Feb. 17, 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory _____
 Location to Washington, D. C.
 18. Funeral director Robert H. McQuire
 Address 1820 9th St N.W. Washington D. C.
 19. Feb. 17, 1946 Rowlands, Phillips
 (Date rec'd by registrar) Registrar

Major findings of operations _____ Date of op. _____
 Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.
 22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____
 23. SIGNATURE Daniel Leo Punicane M.D.
Glenn Dale, Md. M. D. or other _____
 Address _____ Date signed 2.17.46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

FEB 22 1946

BUREAU U S

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charlen St., Baltimore 1312

CERTIFICATE OF DEATH

Reg. Dist. No. 0178245

I. PLACE OF DEATH

County Prince GeorgesCity or town Lakoma Park
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince GeorgesCity or town Lakoma Park
(If outside city or town limits, write RURAL and give nearest town)Street No. 6806 New Hampshire Ave.
(If rural, give LOCATION)2.(a) If veteran, name war No

3. (a) FULL NAME

MRS. ANN MATTERN CAMPBELL

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Widowed6.(b) Name of husband or wife Fred B. Campbell7. Birth date of deceased (mo., day, yr.) Dec. 18-1885
6.(c) If alive, give age..... years8. AGE: Years 60 Months 1 Days 13 If less than one day..... hrs. min.9. Birthplace Washington, D.C.
(Town, county, and state)10. Usual occupation Clerk11. Industry or business Columbia Title Co.12. Name Peter Matern13. Birthplace Baltimore, Md.14. Maiden name Christine Dilli15. Birthplace Washington DC16. Informant Miss Christine MaternAddress 6135-30th St NW Wash DC17. Burial Date thereof Feb. 5-46
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Rock Creek CemeteryLocation Washington, D. C.18. Funeral director S. A. Jones Co.Address 2901-14th St., N.W. Wash., D. C.19. Feb 5 46 James Severy
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 2 19 46 at 7:30 AM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
..... 19..... to..... 19.....
and that I last saw him..... alive on..... 19.....

Immediate cause of death

Acute congestive heart failure
Due to cardiovascular
renal disease

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at Work?Deputy medical Examiner23. SIGNATURE James S. Jones M. D. of otherAddress Freshville Date signed 2-2-46

RECEIVED

FEB 7 1946

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (137a)

CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH:

County Prince George's

City or town Takoma Park
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 months

Hospital, institution, or street address where death occurred

502 Delford Place

How long in hospital or institution?

3. (a) FULL NAME

Rachel Leah Kaplan

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widow

6. (b) Name of husband or wife

Hyman

7. Birth date of

deceased (mo., day, yr.)

1882

6. (c) If alive, give age..... years

8. AGE:

68

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

Russian

(Town, county, and state)

10. Usual occupation

House wife

11. Industry or business

Solomon

12. Name

Russian

13. Birthplace

Gedie

14. Maiden name

Russian

15. Birthplace

Albert Kaplan

16. Informant

2702 Oswego Ave Balto Md

17. (Burial, cremation, or removal. Which?)

Burial

Date thereof. 2-17-46

(month) (day) (year)

Cemetery or crematory

Hebrew Herring Lems

Location

JACK LEVINS INC

18. Funeral director

2600 Eutaw Place Balto Md

19. (Date rec'd by registrar)

Feb 16

1946

J W Duddy

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

md

County

City or town

Baltimore

Street No.

2702 Oswego Ave

(If rural, give LOCATION)

2. (a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH

16 Feb 1946 at 11:30 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

21 Jan 1946 to 16 Feb 1946

and that I last saw her alive on 16 Feb 1946

Immediate cause of death

hepatitis, chronic, interstitial

DURATION

5 years

Due to

arteriosclerosis

Due to

Other conditions

anemia -

venous

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town)..... (County)..... (State).....

Injured at home, farm, industry, public place (where?).....

Means of injury

Injured at work?

23. SIGNATURE

5522 WESTERN M. D. AVE

CHEVY CHASE, MD. 16 Feb 46

RECEIVED
FEB 20 1946
BUREAU V R

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (31-a)

CERTIFICATE OF DEATH

Reg. Dist. No. 232

1. PLACE OF DEATH:

County Prince Georges
 City or town Upper Marlboro
 (Outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 4 years
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince Georges
 City or town Upper Marlboro
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3.(a) FULL NAME

Henry Childs

3.(b) Social Security Number

4. Sex

Male

5. Color or race

Colored

6.(d) Single, married, widowed, or divorced

Single

6.(b) Name of husband or wife

7. Birth date of

deceased (mo., day, yr.)

Dec 26, 1904

6.(c) If alive, give age _____ years

8. AGE:

Years

Months

Days

If less than one day

41123

hrs.

min.

9. Birthplace

Virginia
(Town, county, and state)

10. Usual occupation

Laborer

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Feb 16 1946 at 9:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

18.

19.

and that I last saw him _____ alive on _____ 19 _____

Immediate cause of death

Acute Congestive
Heart Failure
Cardiovascular
Renal disease

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

James D. C. Forestall

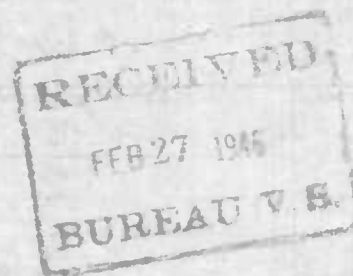
M. D. or other

Address

Date signed 2-26-46

UNITED STATES DEPARTMENT OF JUSTICE

STATE NO. 176-111111



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH:

County Prince George's
 City or town (rural) Glenn Dale, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 2 yrs., 7 mos., 26 days
 Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
 How long in hospital or institution? 2 yrs., 7 mos., 26 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State D. C. County _____
 City or town Washington
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 741 - 5th St. S. E.
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

William A. Coates

3. (b) Social Security Number

579-05-3031

4. Sex

Male

5. Color or race

Colored

6. (a) Single, married, widowed, or divorced

Married (sep.)

6. (b) Name of husband or wife

Phyllis Coates

7. Birth date of deceased (mo., day, yr.)

April 26, 1906

6. (c) If alive, give age _____ years

38

8. AGE:

Years

Months

Days

If less than one day

39928

..... hrs. min.

9. Birthplace

Washington, D. C.

(Town, county, and state)

10. Usual occupation

Chauffeur

11. Industry or business

FATHER

12. Name William Coates13. Birthplace Baltimore, Maryland

MOTHER

14. Maiden name May Frances Johnson15. Birthplace Baltimore, Maryland

16. Informant

Decedent

Address

17. Removal to
(Burial, cremation, or removal. Which?)Date thereof Feb 25, 1946
(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19.

Feb 23, 1946 Rowland S. Philips
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

2-23-46 at 12 Noon

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

5-24-43 to 2-23-46
and that I last saw him alive on 2-23-46

Immediate cause of death

Pulmonary tuberculosis

DURATION

5 years

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Daniel Leo Pinneane MD
M. D. or other

Address

Glenn Dale, Md.Date signed 2-23-46

RECEIVED
MAR 1 1945
BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dlat. No. 01787
234

1. PLACE OF DEATH:

County Prince George
 City or town Chapel Hill
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 8 years
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State md County Prince George
 City or town Chapel Hill Md
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 8720 Livingston Rd
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Walter Coleman

3. (b) Social Security Number

577-12-9978

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male Col. Married

6. (b) Name of husband or wife Mammie May Coleman7. Birth date of deceased (mo., day, yr.) Nov 26 1909 6. (c) If alive, give age years8. AGE: Years Months Days If less than one day
36 hrs. min.9. Birthplace Quendly, Md
(Town, County, and state)10. Usual occupation Machinist Helper

11. Industry or business

12. Name David William Coleman13. Birthplace Wash D.C14. Maiden name Nellie Lee Henson15. Birthplace Prince George, Md16. Informant Syle ColemanAddress 8720 Livingston Rd17. Burial (Burial, cremation, or removal, Which?) Date thereof Feb. 5 1946Cemetery or crematory Chapel HillLocation Chapel Hill18. Funeral director John T. HinesAddress 401-3rd St. N. Wash D.C19. Feb. 2 19 46 Mrs. Alton Davis
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 2 19 46 at 10 M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 31 19 46 to Feb 2 19 46and that I last saw him alive on January 31 19 46Immediate cause of death acute cardiac dilatationDue to toxemia DURATION 1 dayDue to Broncho pneumonia 1 weekOther conditions Uremia 3 weeks

(Include pregnancy within 3 months of death)

Major findings of operations

Antopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Laurence H. Jackson M. D. or otherAddress 1281 New Jersey Ave Date signed 2-2-46

MASSACHUSETTS DEPARTMENT OF HEALTH

STATE OF MASSACHUSETTS

RECEIVED

FEB 8 1946

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01788

★ Reg. Dist. No. 231

1. PLACE OF DEATH:

County Prince George
 City or town Chebeco
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 4 days
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution? 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince George
 City or town Lyttlesville
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 4210 Jefferson St.
 (If rural, give LOCATION)
 2. (a) If veteran, name war

3. (a) FULL NAME

Mary E. Coughlan

3. (b) Social Security Number

4. Sex 7 5. Color or race w 6. (a) Single, married, widowed, or divorced - Widowed
 6. (b) Name of husband or wife
 6. (c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) Feb. 17 1869
 8. AGE: Years 76 Months _____ Days _____ If less than one day _____ hrs. _____ min.

9. Birthplace Mass. (Town, county, and state)
 10. Usual occupation Home maker
 11. Industry or business
 12. Name Robert Dwyer
 13. Birthplace Mass.
 14. Maiden name Catherine Galtier
 15. Birthplace Scotland

16. Informant Dr. Wm. B. Coughlan
 Address 4210 Jefferson St. Lyttlesville, Md.
 17. Burial Date thereof Feb 2 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Boston, Mass
 Location St. St. Chambers Co
 18. Funeral director Riverdale Md.
 Address

19. 2/1 46 Amanda Douney
 (Date rec'd by registrar) (year) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-1 19 46 at 2:30 p.m.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12-24 19 46 to 2-1 19 46 and that I last saw him alive on 1-31 19 46.
 Immediate cause of death Concussion of
Gull bladder with vaginal
intention Rplac abt t'n
 DURATION 3 mo 8
 Due to
 Due to
 Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Rplac abt t'n
75% uterine rupture Date of op. Dec 24-46
 Autopsy results
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work?

23. SIGNATURE W B Dwyer M.D.
 Address St. Raimis Md Date signed 2-1-46

RECEIVED STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED
FEB 3 1946
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01789

Reg. Dist. No. 243

1. PLACE OF DEATH:

County Prince George's
 City or town (Rural) Glenn Dale, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 22 days
 Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
 How long in hospital or institution? 22 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State D. C. County _____
 City or town Washington, D. C.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1738 - 8th St. N. W.
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

LORENZO CURRY

3. (b) Social Security Number

-

4. Sex

Male

5. Color or race

Colored

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) August 21, 1907
 6. (c) If alive, give age _____ years

8. AGE:

Years

Months

Days

If less than one day

3866

hrs.

min.

9. Birthplace

Washington, D. C.

(Town, county, and state)

10. Usual occupation

Elevator Operator

11. Industry or business

FATHER

12. Name Silas Curry

13. Birthplace

Virginia

MOTHER

14. Maiden name Bessie Jones

15. Birthplace

Virginia

18. Informant

Decedent

Address

17.

Removal Date thereof 2-28-46
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory

to Washington D.C.

Location

18. Funeral director

W Ernest Jarvis co

Address

1432 York St NW

19.

Feb. 27, 1946 Rowland S. Phillips
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH FEBRUARY 27, 1946 at 9:30 p. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
February 5, 1946 to Feb. 27, 1946
 and that I last saw him alive on Feb. 27, 1946

Immediate cause of death

PULMONARY TUBERCULOSIS

DURATION

5 yrs

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Daniel Leo Finucane MD

M. D. or other

Address

Glenn Dale MdDate signed 2/27/46

RECEIVED
MAR 6 1946
BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 732

CERTIFICATE OF DEATH

01790

Reg. Dist. No. 231

1. PLACE OF DEATH:

County Prince George
 City or town Chesley, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 14 days
 Hospital, institution, or street address where death occurred:
Prince George General Hospital
 How long in hospital or institution? 14 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Md. County Prince George
 City or town Chesley, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Cross Highway
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Demary Mrs. Mary (Mary E. De Mar.)

3. (b) Social Security Number

4. Sex F 5. Color of face W 6. (a) Single, married, widowed or divorced married
 6. (b) Name of husband or wife Harry E. De Mar
 6. (c) If alive, give age 63 years
 7. Birth date of deceased (mo., day, yr.) Aug. 3, 1889
 8. AGE: Years 57 Months 7 Days _____ If less than one day _____ hrs. _____ min.

9. Birthplace Md. (Town, county, and state)
 10. Usual occupation House wife
 11. Industry or business _____
 12. Name Thomas Kinnaman
 13. Birthplace Md.
 14. Maiden name Mary Eileen Carroll
 15. Birthplace D.C.

15. Informant Mrs. Eliz. Cross
 Address Farrestville, Md.
 17. Burial Date thereof 2-26-46
 (Burial, cremation, or removal, Which?) (month) (day) (year)
 Cemetery or crematory Washington National
 Location Landover, Md.
 18. Funeral director Edwin Brothers
 Address Upper Marlboro, Md.
 19. 2/24 1946 Amanda Downey
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 23 1946 at 1:50 P
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 7 1946 to Feb 23 1946 and that I last saw him alive on Feb 23 1946
 Immediate cause of death
Cerebral Hemorrhage DURATION 2 hrs
 Due to Hypertension Cardio-
Vascular - Renal
Disease 10 yrs
 Other conditions Arteriosclerosis 10 yrs
 (Include pregnancy within 3 months of death)

Major findings of operations None Date of op. _____
 Autopsy results No
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____
 23. SIGNATURE James E. Sarscoe M. D. or other _____
 Address Upper Marlboro, Md. Date signed 2-23-46

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECORDED
FEB 26 1946
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (4)

CERTIFICATE OF DEATH

01791

Reg. Dist. No. 234

1. PLACE OF DEATH:

County Prince George's
 City or town Oxon Hill - 2101 - Overland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 8 years
 Hospital, institution, or street address where death occurred:

How long in hospital or institution? none

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince George's
 City or town Oxon Hill - Md
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 2101 Owens Road Washington DC
 (If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

Martha Ann Demmonson

3. (b) Social Security Number

4. Sex Female 5. Color or race W 6. (a) Single, married, widowed, or divorced widowed

6. (b) Name of husband or wife

Thomas Ellsworth

7. Birth date of deceased (mo., day, yr.)

June 3 1872

6. (c) If alive, give age years

8. AGE:

73

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

(Town, county, and state)

Maryland

10. Usual occupation

Housewife

11. Industry or business

Home

FATHER

12. Name

John Henry Casady

13. Birthplace

Maryland

MOTHER

14. Maiden name

Sarah Ann Owens

15. Birthplace

Maryland

16. Informant

Marjorie Beall

Address

Owens Road - 20 DC

17.

(Burial, cremation, or removal. Which?)

Burial

Date thereof

Feb 9 - 1946

(month) (day) (year)

Cemetery or crematory

St Ignatius

Location

Oxon Hill Maryland

18. Funeral director

Thomas J. Murray

Address

2007 - Nichols Ave SE Wash

19.

(Date rec'd by registrar)

Feb. 7 1946 Howard J. Beall

Registrar

MEDICAL CERTIFICATION

2D. DATE OF DEATH Feb 7 1946 at 10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Oct 31 1945 to Feb 6 1946and that I last saw him/her alive on Feb 6 1946Immediate cause of death acute myocardial failure

DURATION

1 dayDue to Cardiovascular renal disease

Due to

Other conditions Diabetes Mellitus

(Include pregnancy within 3 months of death)

Major findings of operations

none

Date of op.

Autopsy results

none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Paul J. Van Vleet

M. D. or other

Address Washington 1905 Date signed



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13

CERTIFICATE OF DEATH

01792

Reg. Dist. No. 243

1. PLACE OF DEATH:

County Prince George's
 City or town (rural) Glenn Dale, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 14 days
 Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
 How long in hospital or institution? 14 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State D. C. County _____
 City or town Washington
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 433 - 4th St. S. W.
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

DER QUAI, SAM

3. (b) Social Security Number

4. Sex Male 5. Color or race Chinese 6. (a) Single, married, widowed, or divorced Single
 6. (b) Name of husband or wife _____
 6. (c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) November 19, 1875
 8. AGE: Years 70 Months 2 Days 20 If less than one day _____ hrs. _____ min.

9. Birthplace China
 (Town, county, and state)
 10. Usual occupation Laundry
 11. Industry or business _____

FATHER 12. Name Yen Der Quai
 13. Birthplace China
 MOTHER 14. Maiden name Wan Hung
 15. Birthplace China

16. Informant Decedent
 Address _____
 17. Removal
 (Burial, cremation, or removal. Which?) Date thereof Feb. 8, 1946
 (month) (day) (year)

Cemetery or crematory _____
 Location to Washington D.C.
 18. Funeral director W. W. Chamber Co.
 Address 1400 Chapin Wash. D.C.

19. Feb. 8, 1946 Rowland J. Phillips
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Febr. 8, 1946 at 2:20 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1/25 1946, to 2/8 1946, and that I last saw him alive on 2/8 1946.

Immediate cause of death Mitral stenosis + Insufficiency DURATION 20 yrs

Due to Diabetes Mellitus 6 yrs

Due to _____

Other conditions Pulmonary Tuberculosis 3 wks

(Include pregnancy within 3 months of death)

Major findings of operations _____

_____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Daniel Leo Pinucane M.D. M. D. or other _____

Address Glenn Dale, Md. Date signed 2/8/46

FEB 16 1946

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 107

CERTIFICATE OF DEATH

Reg. Dist. No.

237

1. PLACE OF DEATH:-

County Prince Georges

City or town Baden
(Outside city or town limits, write RURAL and give nearest town)

How long in above place of death? all life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Prince Georges

City or town Baden
(If outside city or town limits, write RURAL and give nearest town)

Street No. —
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Ruth Marion Douglas

3. (b) Social Security Number

4. Sex Female 5. Color or race Colored 6.(a) Single, married, widowed, or divorced single

6.(b) Name of husband or wife —

6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Dec. 13 - 1945

8. AGE: Years 1 Months 2 Days 4 If less than one day — hrs. — min.

9. Birthplace Brandywine, Md
(Town, county, and state)

10. Usual occupation Infant

11. Industry or business

FATHER 12. Name Rodney Douglas
13. Birthplace Prince Georges, Md

MOTHER 14. Maiden name Pearl Henson

15. Birthplace Prince Georges, Co

16. Informant Pearl Henson

Address Brandywine, Md

17. Burial (Burial, cremation, or removal. Where?) Feb. 8, 1946
(month) (day) (year)

Cemetery or crematory St. Thomas Cemetery

Location Baden, Md

18. Funeral director G. J. James

Address Agnasco, Md

19. Date rec'd by registrar Feb 8th 1946 Registrar Mrs H. B. Carter

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 6 1946 at 8 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from and Feb 5 1946 to Feb 6 1946 and that I last saw her alive on Feb 5th 1946

Immediate cause of death Pneumonia DURATION one week

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John E. Bowers, MD M. D. or other

Address Brandywine, Md Date signed 2/7/46

MARGIN RESERVED FOR BINDING

9.45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

FEB 9 1946

BUREAU V.B.

Evidence for change of age
of deceased is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 9370

01794

FILM No. 100 FEB 18 1946

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH:

County Pro Geo Co

City or town Colmar Manor Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 months

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Pro Geo Co.

City or town Colmar Manor Md

(If outside city or town limits, write RURAL and give nearest town)

Street No. 3418 - 40th Ave

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME

John a. Slowning

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife Mamie Slowning

7. Birth date of deceased (mo., day, yr.) Oct 15, 1872.

6. (c) If alive, give age..... years

8. AGE: Years 73 Months 4 Days 4 If less than one day..... hrs. min.

9. Birthplace New Jersey

(Town, county, and state)

10. Usual occupation Magistrate

11. Industry or business

12. Name Patrick Slowning

13. Birthplace Ireland

14. Maiden name Margaret Spillane

15. Birthplace Ireland

18. Informant Mamie Slowning (wife)

Address Colmar Manor Md

17. Burial Date thereof Feb 5, 1946

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Evergreen Cemetery

Location Bladensburg Md.

18. Funeral director F. Geske sons

Address Hyattsville Md.

19. 2/4 1946 Amanda Downey

(Date reg'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 2, 1946, at 11:45 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan. 1 1940 to Feb 2 1946

and that I last saw him alive on Feb. 1 1946

Immediate cause of death Myocardial

infarction ex. hypercholesterolemia

degeneration

Due to arteriosclerosis

Due to.....

Other conditions.....

(Include pregnancy within 9 months of death)

Major findings of operations.....

..... Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE C. M. Keats M. D. or other

Address Hatfield Rd Date signed 24 46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
FEB 6 1946
BUREAU V B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 342

1. PLACE OF DEATH:

County Prince George'sCity or town Southland Md.
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 3 yrsHospital, institution, or street address where death occurred: —How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince George'sCity or town Southland Md.
(If outside city or town limits, write RURAL and give nearest town)Street No. 4811 Southland Rd Washington 208
(If rural, give LOCATION)2.(a) If veteran, name war — none —

3. (a) FULL NAME

Thomas Alexander Elrod.

3. (b) Social Security Number

249-24-5765

4. Sex

m

5. Color or race

w

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

Ida Inez Elrod.

7. Birth date of

deceased (mo., day, yr.)

Oct 14 18886. (c) If alive, give age 8 years

8. AGE:

Years

Months

Days

If less than one day

65

hrs.

min.

9. Birthplace

Anderson Co., So. Carolina
(Town, county, and state)

10. Usual occupation

carpenter

11. Industry or business

Self

FATHER

MOTHER

12. Name

Thomas A. Elrod

13. Birthplace

Anderson Co., So. Carolina

14. Maiden name

Cynthia Hankins

15. Birthplace

So. Carolina

16. Informant

Mrs Thomas A Elrod

Address

4811 Southland Rd Washington 20817. Burial

(Burial, cremation, or removal, Which)

Date thereof

2-28-46

Cemetery or crematory

Wash. Natl.

Location

Southland Md.

18. Funeral director

W.W. Chambers Co

Address

517 11th St S.E.19. 2/26

(Date rec'd by registrar)

19. 46

Carrie F. Lambell

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 26 1946 at 8:30 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 1 1945 to Feb 26 1946and that I last saw him alive on Feb 25 1946

Immediate cause of death

sudden or sudden
cardiac failure

Due to

Carcinoma of
Pancreas with metastases

Due to

Other conditions

—

(Include pregnancy within 3 months of death)

Major findings of operations

multiple carcinomas
area. Pancreatic margin

Autopsy results

none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

none

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

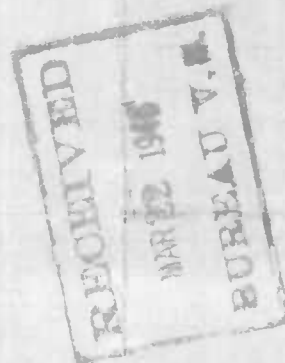
Means of injury

—

Injured at work?

23. SIGNATURE

Paul C Van Yatta
5440 Silver Spring Rd M. D.
Washington 19 Date signed Feb 26
1946



Copy sent to Co. H.O. 9/22/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1790

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County Pro Geo Co
City or town Halls
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 year
Hospital, institution, or street address where death occurred:
Crown Highway 1/2 mile north of Halls
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Connecticut County New Haven
City or town Millford Conn.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 149 New Haven Ave
(If rural, give LOCATION)
2. (a) If veteran, name war

3. (a) FULL NAME

Lucius Richard Erarte

3. (b) Social Security No.

4. Sex

male

5. Color or race

white

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

Burtha P Erarte

7. Birth date of deceased (mo., day, yr.)

Oct 21. 1885

6. (c) If alive, give age

61 years

8. AGE:

Years

Months

Days

If less than one day

60

hrs.

min.

9. Birthplace

Connecticut

(Town, county, and state)

10. Usual occupation

Painter & Int. Decorator

11. Industry or business

own Business

FATHER

12. Name

Benjamin Erarte

13. Birthplace

Bridgeport Mich.

MOTHER

14. Maiden name

Clara Van Dusen

15. Birthplace

N. Y.

16. Informant

Russell B Erarte

Address

149 New Haven Ave Millford Conn

17. Transportation

Transportation

Date thereof

Feb. 6, 1946

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Millford

Location

Connecticut

18. Funeral director

F. G. Cooks sons

Address

Hyattsville Maryland

19. (Date rec'd by registrar)

2/6

19

46 Ananda Downey

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Feb. 5 1946

21. I CERTIFY that death occurred on the date above stated; that I attended deceased

and that I last saw him alive on

Immediate cause of death

hemorrhage and shock

Due to

fracture of skull (compound)

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? Halls

(City or town)

Injured at home, farm, industry, public place (where?)

Means of injury Auto collision

Injured at work? No

23. SIGNATURE

James D. ...

Address

Date signed

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED

FEB 8 1946

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13

CERTIFICATE OF DEATH

Reg. Dist. No. 01797 243

1. PLACE OF DEATH:

County Prince George's
 City or town (rural) Glenn Dale, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 2 yrs., 14 days
 Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
 How long in hospital or institution? 2 yrs., 14 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State D. C. County _____
 City or town Washington
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1526 Good Hope Rd. S. E.
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

CHARLES F. FERGUSON

3. (b) Social Security Number

?

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Anne M. Ferguson6. (c) If alive, give age 30 years

7. Birth date of

deceased (mo., day, yr.)

August 19, 1915

8. AGE:

Years

Months

Days

If less than one day

30513

hrs.

min.

9. Birthplace

Washington, D. C.

(Town, county, and state)

10. Usual occupation

Service Manager

11. Industry or business

FATHER

12. Name

Charles F. Ferguson

13. Birthplace

Washington, D. C.

MOTHER

14. Maiden name

Martha E. Woran

15. Birthplace

Charles Co., Maryland

16. Informant

Decedent

Address

17.

(Burial, cremation, or removal. Which?)

Date thereof

Feb. 1, 1946

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

19

Feb. 1, 1946 Rowland S. Phillips

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 1, 1946 at 1:25 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan. 181944Feb. 11946

and that I last saw him alive on

Feb. 11946

Immediate cause of death

Pulmonary Tuberculosis

DURATION

2 yrs.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Daniel Leo Pinucane M.D.

M. D. or other

Address

Glenn Dale, Md.

Date signed

2/1/46

RECEIVED
FEB 5 1946
BUREAU V.B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 940

CERTIFICATE OF DEATH

01798

Reg. Dist. No.

245

1. PLACE OF DEATH:

County Prince Georges

City or town Riverdale Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 1/4 hrs.

Hospital, institution, or street address where death occurred:
Leland Memorial Hospital

How long in hospital or institution? 3 1/4 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County

City or town Greenbelt
(If outside city or town limits, write RURAL and give nearest town)Street No. 22 C Hillside Rd.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

James Qshby Flynn

3. (b) Social Security Number

4. Sex male

5. Color or race white

6.(a) Single, married, widowed, or divorced

widowed

6.(b) Name of husband or wife: Ralph Flynn

deceased

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 15, 1900

8. AGE: Years 45 Months 2 Days 29 hrs. min.

9. Birthplace Washington, D.C.
(Town, county, and state)

10. Usual occupation Attorney

11. Industry or business Veterans Administration

12. Name James Qshby Flynn

13. Birthplace Washington, D.C.

14. Maiden name

15. Birthplace Washington, D.C.

16. Informant Marcey D. Mermineather

Address 5216 - 4th St. N.W. Wash. D.C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2-16-45
(month) (day) (year)

Cemetery or crematory Congressional Cemetery

Location Wash. D.C.

18. Funeral director W. W. Chaubko &

Address Riverdale Md

19. Kelly 15 1946 James Seery

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 14 1946 at 6:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

February 1 1945 to Feb 7 1946

and that I last saw him alive on Feb 7 1946

Immediate cause of death Coronary Occlusion

DURATION

Due to Coronary Sclerosis

Due to

Other conditions Mild hypertension

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE William H. Eisner M.D. or other

Address 30 B. Ridge Rd. Date signed 4/15/46

Greenbelt Md

RECEIVED

FEB 18 1946

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13-1

CERTIFICATE OF DEATH

01799

Reg. Dist. No. 243.

1. PLACE OF DEATH:

County Prince George's
 City or town (rural) Glenn Dale, Maryland
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 mos., 13 days

Hospital, institution, or street address where death occurred:

Glenn Dale Sanatorium
 How long in hospital or institution? 2 mos., 13 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State D. C. County Washington

City or town Washington
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 642 L. Street S. E.
 (If rural, give LOCATION)

2.(a) If veteran, name war - ✓

3. (a) FULL NAME

GANT, JAMES EDW.

3. (b) Social Security Number

?

4. Sex

Male

5. Color or race

Colored

6. (a) Single, married, widowed, or divorced

Widowed

8. (b) Name of husband or wife

?

6. (c) If alive, give age 45 years

7. Birth date of

deceased (mo., day, yr.)

May 28, 1881

8. AGE:

Years

Months

Days

If less than one day

64811hrs.min.

9. Birthplace

Prince George's Co., Maryland

(Town, county, and state)

10. Usual occupation

Laborer

11. Industry or business

FATHER

12. Name

Wesley Gant

13. Birthplace

Prince George's Co., Maryland

MOTHER

14. Maiden name

Ann Lynn

15. Birthplace

Prince George's Co., Maryland

16. Informant

Decedent

Address

17.

Removal
(Burial, cremation, or removal. Which?)Date thereof Feb. 8, 1946
(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19.

Feb. 8, 1946
(Date rec'd by registrar)Rowland S. Phillips
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 8, 1946 at 6:20 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

11/26 19 45 to 2/8 19 46and that I last saw him alive on 2/8 19 46

Immediate cause of death

pulmonary tuber-
culosis

DURATION

3 mos.

Due to

Due to

Other conditions

myocarditis,
chronic nephritis
(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide - Date of -Where did injury occur? - (City or town) (County) (State)Injured at home, farm, industry, public place (where?) -Means of injury - Injured at work? -

23. SIGNATURE

Daniel Leo Pinecone M.D.
Address Glenn Dale Md. Date signed 2/8/46

FEB 16 1946

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of birth date of deceased is shown on 2411 N. Charles St., Baltimore (46-4)

MARYLAND STATE DEPARTMENT OF HEALTH

01800

CERTIFICATE OF DEATH

Reg. Dist. No. 239

FILM No. 100 MAR 6 1946

1. PLACE OF DEATH:

County Prince George's
City or town Land (If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: _____

Stay in hospital or inst. (yrs., or mos., or days) _____

Stay in this community (yrs., or mos., or days) 47 years

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Prince George's
City or town Land (If outside city or town limits, write RURAL NEAR and give town) Ward No. _____
Street No. 43 A St. (If rural give LOCATION)
2(a) IF VETERAN, NAME WAR _____

3. (a) FULL NAME

Rachel Patricia Reis

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Leonard J. Reis

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) July 9 - 1866 - 18658. AGE: Years 80 Months 7 Days 0 If less than one day _____ hrs. _____ min.9. Birthplace Charters, Queen Anne's Co. Md. (Town, county, and state)10. Usual occupation Housewife11. Industry or business Owner home12. Name Mildred Greenberg Simon13. Birthplace Charters Md.14. Maiden name Margaret Eliza Legg15. Birthplace Charters Md.16. Informant Elise Reis LucasAddress 10111 Park, Md.17. Burial Date thereof 2/22/46
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Laurel HillLocation Laurel Md.18. Funeral director Lloyd KaiserAddress Laurel Md.19. Feb. 22 19 46 C. E. Wachter
(Date rec'd by registrar) (month) (day) (year) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 19 19 46, at 11 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 1 19 46 to Feb 19 19 46, and that I last saw her alive on Feb 19 19 46

Immediate cause of death

Exhaustion of return

DURATION

1 mo.Due to Exhaustion of return
Exhaustion of return1 yr.
4 yrs.

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings: _____

Of operations: _____

Of autopsy: _____

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE

Robert J. McInerney M.D.
Address Land Md. Date signed 2/19/46

PHYSICIAN

Please underline the cause to which death should be charged statistically.

RECEIVED
FEB 27 1946
BUREAU V.B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age of deceased is shown on

Evidence for change of age of deceased is shown on

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore 46

CERTIFICATE OF DEATH

FILM No. I 00 FEB 26 1946

Reg. Dist. No. 231

1. PLACE OF DEATH:

County Prince George

City or town Chesapeake
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 days

Hospital, institution, or street address where death occurred

Prince George's Gen. Hosp.

How long in hospital or institution? 10 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md. County Prince George

City or town W. Lanham Hills
(If outside city or town limits, write RURAL and give nearest town)

Street No. 5701

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

Gephart Mrs. Maggie

3. (b) Social Security Number

4. Sex F. 5. Color or race W. 6. (a) Single, married, widowed, or divorced W.

6. (b) Name of husband or wife.....

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) Feb. 26, 1871

8. AGE: Years 74 Months 75 Days 11 If less than one day 13 hrs. min.

9. Birthplace Pa.
(Town, county, and state)

10. Usual occupation House wife

11. Industry or business

12. Name Jacob Griffith

13. Birthplace Pa.

14. Maiden name Barbara Geller

15. Birthplace Pa.

16. Informant J. Brock, Mrs. Evelyn (Daughter)

Address 5701 W. Lanham Hills Md.

17. (Burial, cremation, or removal. Which?) By train Date thereof 2/14/46
(month) (day) (year)

Cemetery or crematory New Enterprise Cemetery

Location New Enterprise Pa.

18. Funeral director W. Chambers

Address Riverdale, Md.

19. 2/13 19 46 Ramond Journey
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-13 19 46 5:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

..... 19..... to..... 19.....

and that I last saw h..... alive on..... 19.....

Immediate cause of death.....

Gdeno-carcinoma stomach

Other conditions Heart's bilious cirrhosis

of liver (atrophic phase) cardiac hypertrophy

(Include agency within 72 hours of death)

Major findings of operations.....

..... Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

Signature W. Chambers

23. SIGNATURE..... M. D. or other

Address..... Date signed 2/13/46

MAINE AND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FEB 16 1946

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 01802 239

1. PLACE OF DEATH:

County Prince Geo.City or town Rural
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 3 days

Hospital, institution, or street address where death occurred:

Mr Davis Chastain Home

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Balto.City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Sally Gale Glann

3. (b) Social Security Number

4. Sex F. 5. Color or race W 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife _____

7. Birth date of deceased (mo., day, yr.) Feb. 27 - 1945
8. (c) If alive, give age _____ years8. AGE: Years 11 Months 31 Days _____ If less than one day _____ hrs. _____ min.9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual occupation _____

11. Industry or business _____

12. Name Frederick H. Glann

13. Birthplace _____

14. Maiden name Marguerite Schurz

15. Birthplace _____

16. Informant Mr Francis GregorAddress Mr Davis Home17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 27-46
(month) (day) (year)Cemetery or crematorium Maryland Maus. P. Cem.Location Baltimore, Md.18. Funeral director Floyd KaiserAddress Laurel Md.19. Feb. 27 19 46 Car E Wachter
(Date rec'd by registrar) Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 25 - 19 46 at 4:45 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 23 19 46 to Feb. 25 19 46
and that I last saw him alive on Feb. 25 - 19 46

Immediate cause of death _____

Solar pneumonia

DURATION

2 wks

Due to _____

Due to _____

Other conditions _____

pages Requies
maculoblastic

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE _____

Car E Wachter

M. D. or other

Address 305 - Prince Geo St Date signed 2-25-46Laurel Md.

RECEIVED
MAR 4 1946
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 9320

CERTIFICATE OF DEATH

01803 245
Reg. Dist. No.

1. PLACE OF DEATH:

County... Prince George

City or town... Riverdale, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 days

Hospital, institution, or street address where death occurred:

Seland Memorial Hosp. Riverdale, Md.

How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Washington, D.C.

City or town... Washington, D.C.
(If outside city or town limits, write RURAL and give nearest town)Street No. 7077 Central Ave. S.E.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

George W. Gregory

3. (b) Social Security Number

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

married

B. (b) Name of husband or wife

Mrs. Mae Tiffany Gregory

7. Birth date of deceased (mo., day, yr.)

January 4, 1876

6. (c) If alive, give age

68 years

8. AGE:

Years 70

Months 1

Days 12

If less than one day

hrs. min.

9. Birthplace

Brooklyn, New York

(Town, county, and state)

10. Usual occupation

Building Superintendent

11. Industry or business

John Gregory

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19. Date rec'd by registrar

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 16 1946 at 7:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 14 1946 Feb 16 1946

and that I last saw him alive on Feb 16 1946

Immediate cause of death Pulmonary Embolus

DURATION

Due to Phlebotrombosis of left iliac vein

Due to Arteriosclerotic heart disease & grade I failure

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op. Feb 15 1946

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

Address

Date signed

UNITED STATES DEPARTMENT OF JUSTICE

PLEASE DO NOT WRITE ON THIS

NOT RECORDED

EXHIBIT CONTENT

RECEIVED
FEB 20 1946
BUREAU V R

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1312)

CERTIFICATE OF DEATH

Reg. Dist. No. 01812465

1. PLACE OF DEATH:

County Prince GeorgesCity or town Mt. Rainier
(If outside city or town limits, write RURAL and give nearest town)

New long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince GeorgesCity or town Mt. Rainier
(If outside city or town limits, write RURAL and give nearest town)Street No. 3724-35th St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

BARNEY G. Hanback

3. (b) Social Security Number

4. Sex male5. Color or race white6.(a) Single, married, widowed, or divorced married6.(b) Name of husband or wife Ilda Hanback7. Birth date of deceased (mo., day, yr.) July 20, 18708. AGE: Years 75 Months 7 Days hrs. min.

6.(c) If alive, give age years

9. Birthplace Warrenton, Va.
(Town, county, and state)10. Usual occupation Carpenter

11. Industry or business

12. Name William Hanback13. Birthplace Warrenton, Va.14. Maiden name Luey Thear15. Birthplace Warrenton, Va.16. Informant Albert W. SmithAddress 7756-DeCATUR, Rd. Hyattsville, Md.17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof February 18, 1946
(month) (day) (year)Cemetery or crematory Fort Lincoln CemeteryLocation 3201-Bladensburg Rd. Md.18. Funeral director William J. MalloryAddress 3200-R.I. Ave. Mt. Rainier, Md.19. Feb. 18, 1946 (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 15, 1946 at 6:54 A.M.21. CERTIFY that death occurred on the date above stated; that I attended deceased from February 5, 1946 to February 15, 1946and that I last saw him alive on February 14, 1946Immediate cause of death Cardiovascular renal diseaseDURATION 1 year

Due to

Due to

Other conditions Cerebral thrombosis 1 day

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

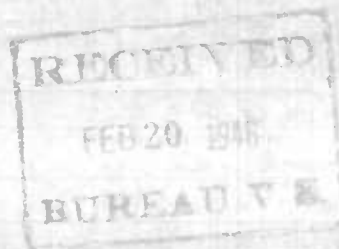
Means of injury Injured at work?

23. SIGNATURE [Signature]Address Mt. Rainier, Md. Date signed 2/16/46

M. D. or other

Dr. Boyd, County Coroner,
As testified by me and will
approve.

[Signature]



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 01805 231

1. PLACE OF DEATH:

County Prince George'sCity or town Cheverly
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Prince George's General Hospital

How long in hospital or institution?

5 hrs 40 min

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince George's CountyCity or town Landover
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Carl Heinmuller, Sr.

3. (b) Social Security Number

219-16-5667

4. Sex

male

5. Color or race

white6. (a) ~~Single~~, married, widowed, ~~divorced~~Divorced

6. (b) Name of husband or wife

Helen Eichner6. (c) If alive, give age 63 years

7. Birth date of

deceased (mo., day, yr.)

July 11- 1881

8. AGE:

Years

Months

Days

If less than one day

64630

.....hrs.min.

9. Birthplace

Anne Arundel, Baltimore, Maryland
(Town, county, and state)

10. Usual occupation

Baker

11. Industry or business

Prince George's Gen. Hospital

FATHER

12. Name

Adam Heinmuller

13. Birthplace

Germany

MOTHER

14. Maiden name

Maria Stahl

15. Birthplace

Germany

16. Informant

Carl Heinmuller Jr.Address 3200 - Mifflin Ave. Balto. Md.

17.

(Burial, cremation, or removal, which?)

Date thereof

Feb. 14, 1946
(month) (day) (year)

Cemetery or crematorium

Louisa Park

Location

Baltimore

18. Funeral director

Phillip Lamoreau

Address

4510 Liberty Heights Ave., Balto., Md.

19.

(Date read by registrar)

19. 46Carl Heinmuller

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 10 19 46 at 6:10 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb 10 19 46 to Feb 10 19 46and that I last saw him alive on Feb 10 19 46

Immediate cause of death

Coronary
occlusion

DURATION

Due to

coronary thrombosis

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

John M. Lamoreau
M. D. or other

Address

Prince Geo. Gen. Hosp.
Cheverly

Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1312

CERTIFICATE OF DEATH

Reg. Dist. No. 1806 245

1. PLACE OF DEATH:

County Prince Geo. Co.
 City or town Brentwood
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 25 years
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Pr. Geo. Co.
 City or town Brentwood
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 3412 - Webster St
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

James Ogle Henderson

3. (b) Social Security Number

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced married6. (b) Name of husband or wife Ella Virginia Henderson7. Birth date of deceased (mo., day, yr.) March 2, 1880 8. (c) If alive, give age.....years8. AGE: Years 65 Months 11 Days 14 If less than one day
.....hrs.min.9. Birthplace Va
(Town, county, and state)10. Usual occupation night watchman

11. Industry or business

12. Name James Henderson13. Birthplace Va14. Maiden name unknown15. Birthplace Va16. Informant James G. HendersonAddress 3407 - Bunker Hill Rd Mt. Rainier Md17. Burial Date thereof 2-18-46
(Burial, cremation, or removal. Which) (month) (day) (year)Cemetery or crematory Ft. Lincoln CemeteryLocation Wash Dc18. Funeral director W. W. ChambersAddress Riverdale, Va19. 24-17 1946 James Severy
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 16 1946 at 4:00 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

.....19..... to19.....

and that I last saw him.....alive on19.....

Immediate cause of death..... DURATION

acute congestive heart failureDue to Cardiovascular renal disease

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

.....Date of op.

Antopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

deputy medical examiner23. SIGNATURE James I. Lord M. D. or otherAddress 76 Westcott Rd Date signed 2-16-46

CERTIFICATE OF DEATH

RECEIVED
FEB 20 1946
BUREAU V. L.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 30-9

CERTIFICATE OF DEATH

01807

Reg. Dist. No.

239

1. PLACE OF DEATH:

County... Prince George
 City or town... Conte Rd near Laurel Md
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 yrs
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Md County... Prince George
 City or town... Laurel
 (If outside city or town limits, write RURAL and give nearest town)

Street No.
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Overton Henderson

3. (b) Social Security Number

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

male colored married

6.(b) Name of husband or wife Nora Henderson7. Birth date of deceased (mo., day, yr.) 6.(c) If alive, give age 60 years

July 27, 1878

8. AGE: Years Months Days If less than one day
67 7hrs.min.

9. Birthplace... Virginia
 (Town, county, and state)

10. Usual occupation Laurel

11. Industry or business

12. Name Charles Henderson13. Birthplace Virginia14. Maiden name Unknown15. Birthplace Unknown16. Informant Nora HendersonAddress Conte Rd Laurel Rd. D

17. Burial Date thereof Mar 5 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory BaconLocation Anne Arundel Co near Laurel18. Funeral director Ridgely WellingAddress 404 Wood Ave Laurel Md

19. Mar 5 1946 M. Brucke
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 27th 1946 at 4 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb 21 1946, to Feb 27 1946and that I last saw him alive on 2-27 1946Immediate cause of death MycobacteriaDisseminatedHeart + Kidney SystemDue to with uremia

DURATION

15 yrs

Due to

Other conditions Syphilis, Latent

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J M Warren MDAddress LaurelDate signed 3-1-46

UNITED STATES DEPARTMENT OF JUSTICE

OFFICE OF THE ATTORNEY GENERAL

WASHINGTON, D. C. 20530

MEMORANDUM FOR THE ATTORNEY GENERAL

DEPARTMENT OF JUSTICE

RECEIVED
MAR 7 1946
BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 170

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH:

County Prince GeorgesCity or town Silver Spring
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Forever

Hospital, institution, or street address where death occurred:

In field near Taylor Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State District of ColumbiaCity or town Washington
(If outside city or town limits, write RURAL and give nearest town)Street No. 615 Portland Street S.E.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Norma Pauline Hersey

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Resto B Hersey

7. Birth date of deceased (mo., day, yr.)

Oct 8, 1909

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

36412

hrs.

min.

9. Birthplace

Missouri
(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

Own Home

MOTHER FATHER

12. Name

John Endule

13. Birthplace

Unknown

14. Maiden name

Unknown

15. Birthplace

Unknown

16. Informant

Resto B Hersey

Address

615 - Portland St S.E. D.C.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

Feb. 22, 1946
(month) (day) (year)

Cemetery or crematory

Illmo Mo.

Location

Missouri

18. Funeral director

J. D. Archer Sons

Address

4737 Baltimore Ave. Hyattsville, Md.

19.

2/21

(Date rec'd by registrar)

19

46Amanda Downes

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Feb 20 1946 at 10:30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

..... 19....., to..... 19.....

and that I last saw him..... alive on..... 19.....

Immediate cause of death

Exposure to cold

DURATION

Due to

Due to

Other conditions

4 1/2 months pregnant

(Include pregnancy within 8 months of death)

Major findings of operations

..... Date of op.

Autopsy results

as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

Deputy Medical Examiner

23. SIGNATURE

James T. Boyd

M. D. or other

Address

Grestville Md

Date signed

2-20-46

RECEIVED
FEB 25 1946
BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 72-6

CERTIFICATE OF DEATH

01809

Reg. Diat. No. 231

1. PLACE OF DEATH:

County Prince Geo. County
 City or town C. Revery, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 36 hrs. 50 min.
 Hospital, institution, or street address where death occurred:
Prince Geo. Gen'l Hosp.
 How long in hospital or institution? 36 hrs. 50 min.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Md. County Pr. Geo.
 City or town Hypattsville
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 5405 38th Ave.
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Higbie, Mrs. Katherine
 4. Sex F 5. Color or race W 6. (a) Single, married, widowed, or divorced

3. (b) Social Security Number

6. (b) Name of husband or wife Mr. Harold Higbie

7. Birth date of deceased (mo., day, yr.) Apr. 25 1878 6. (c) If alive, give age..... years

8. AGE: Years 67 Months..... Days..... If less than one day..... hrs. min.

9. Birthplace M. C. Rigan
 (Town, county, and state)

10. Usual occupation H. W.

11. Industry or business

12. Name Daniel Graham

13. Birthplace M. C. Rigan

14. Maiden name Margaret W. Ida

15. Birthplace Scotland

16. Informant Harold F. Higbie

5405-38th Ave. Hypattsville

17. Burial Date thereof 7/25/46
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. Francis bury

Location Wash. D.C.

18. Funeral director W. W. Chambers Co

Address Riverside, Md.

19. 2/24 1946 Amanda Dorney
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-22 1946, at 5:37 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2-18 1946 to 2-22 1946

and that I last saw him alive on 2-22 1946

Immediate cause of death Bronchopneumonia

caused by acute fulminant

bronchitis

Due to.....

Due to.....

Other conditions mitral endocarditis

with stenosis

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results Same as listed as cause of death.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town)..... (County)..... (State).....

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE Edith W. W.

Address Hypattsville, Md. M. D. or other

Date signed 2/23/46

RECEIVED

FEB 26 1946

BUREAU V. L.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

SACRED HEART HOME

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 Mos

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MD. (b) County ALLEGHANY

(c) City or town FROSTBURG
(If outside city or town limits, write RURAL and give town)

(d) Street No. (If rural give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME

MARGARET BEATRICE HUBER

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

FEMALE WHITE

WIDOWED

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MAY 21, 1887

8. AGE:

Years

Months

Days

If less than one day

63

8

21

hr.

min.

9. Birthplace ELK GARDEN W. VA.

(Town, county, and state)

10. Usual Occupation HOUSEWIFE

11. Industry or business

FATHER
MOTHER

12. Name WILLIAM HINES

13. Birthplace ELK GARDEN, W. VA.

14. Maiden Name ANNA CONDRY

15. Birthplace ELK GARDEN, W. VA.

16 (a) Informant JOSEPH F. HUBER

(b) Address 7904 TILMONT AVE.

17 (a) BURIAL (b) Date thereof 2 14 46
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory ST. MICHAELS
Location FROSTBURG MD.

18 (a) Funeral director A. R. SLADE

(b) Address 4907 YORK RD.

19 (a) 2/12/46
(Date rec'd by registrar)C. E. HEDIN
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 11 1946, at 9:00 PM

21. I certify that death occurred on the date above stated, that I attended deceased from Feb 9 1946, to Feb 11 1946, and that I last saw her alive on Feb 9 46.

Immediate cause of death

Duration

Due to

Due to

Other Conditions

Cardio-arterio
sclerosis

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature C. E. Hedlin

Address 35 N. Y. Ave Date signed Feb 2

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and fully.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (190)

CERTIFICATE OF DEATH

Reg. Dist. No. 242

1. PLACE OF DEATH:

County Prince Georges

City or town Chapel Hill
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 months

Hospital, institution, or street address where death occurred:

Linnington Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince Georges

City or town Chapel Hill
(If outside city or town limits, write RURAL and give nearest town)Street No. Linnington Road
(If rural, give LOCATION)

2(a) If veteran, name war

3. (a) FULL NAME

Catherini Johnson

3. (b) Social Security Number

4. Sex

Female

5. Color or race

Colored

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

8. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

1882

8. AGE:

Years

Months

Days

If less than one day

64

hrs. min.

9. Birthplace

(Town, county, and state)

10. Usual occupation

Domestic

11. Industry or business

MOTHER FATHER

12. Name

Charles Johnson

13. Birthplace

Maryland

14. Maiden name

Marie Stewart

15. Birthplace

Maryland

16. Informant

William H. Johnson

Address

743 - 4th St NW Wash DC

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

Mar. 2, 1946
(month) (day) (year)

Cemetery or crematory

Harmony Ceme

Location

Linnington, D.C.

18. Funeral director

John S. Thomas & Co -

Address

901 - 3rd St. S.W. -

19.

(Date rec'd by registrar)

19

2-25-46

Drene A. Bonner

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 25 1946 at 8:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19

to

19

and that I last saw h. alive on

19

Immediate cause of death

acute congestive heart failure
and myocardial infarction

DURATION

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Address Forest Hill Md Date signed 2-25-46

208-61- P1C:H

RECEIVED

MAR 18 1946

BUREAU V S

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (168)

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH:

County Prince George
 City or town Cheverly
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 days

Hospital, institution, or street address where death occurred:

Prince George's General Hospt.How long in hospital or institution? 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County Prince Geo

City or town Landover, Md.
 (If outside city or town limits, write RURAL and give nearest town)

Street No. R. F. D.
 (If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

Jones, Mrs. Annie

3. (b) Social Security Number

4. Sex

F.

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Jones, Mr. E

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) June 30, 1884

8. AGE: Years Months Days If less than one day

61

..... hrs. min.

9. Birthplace va.

(Town, county, and state)

10. Usual occupation H. W.

11. Industry or business

12. Name Pearson, Mr. Robert13. Birthplace va14. Maiden name HUMMER, Miss Mattie15. Birthplace va16. Informant Tucker, Mrs. MarieAddress Landover Md R. F. D.17. Burial (Burial, cremation, or removal. Which?) BurialDate thereof Feb 15, 1946Cemetery or crematory Andrews ChapelLocation Virginia18. Funeral director F. Gasch's SonsAddress Hyattsville Md

21/3 46 Amanda Dunez

19. (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2 - 12 19 46 at 4 45 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

..... 19....., to..... 19.....

and that I last saw him..... alive on..... 19.....

Immediate cause of death

Cerebral compressionEntia cranial hemisphFracture of skull

DURATION

Dther conditions Rupture of diaphragm

(Include pregnancy within 3 months of death)

Major findings of operations.....

..... Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide homicide Date of 2-7-46Where did injury occur? Hyattsville (City or town) P. G. (County) md (State)Injured at home, farm, industry, public place (where?) on public roadMeans of injury assaulted Injured at work?Deputy Medical Examiner23. SIGNATURE James J. JosephAddress Dreeston, Md. Date signed 2-12-46

FEB 16 1946

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH:

County Prince George's
 City or town (rural) Glenn Dale, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 24 days
 Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
 How long in hospital or institution? 24 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State D. C. County _____
 City or town Washington
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1509 R. Street N. W.
 (If rural, give LOCATION)
 2. (a) If veteran, name war _____

3. (a) FULL NAME

Naomi Jones

3. (b) Social Security Number

?

4. Sex Female 5. Color or race Colored 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Ollie Jones
 6. (c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) June 6, 1919
 8. AGE: Years 26 Months 27 Days 29 If less than one day _____ hrs. _____ min.

9. Birthplace Virginia
 (Town, county, and state)
 10. Usual occupation Laundry Employee
 11. Industry or business _____

FATHER 12. Name Ernest Oliver
 13. Birthplace ?
 MOTHER 14. Maiden name Marian Taylor
 15. Birthplace Virginia

16. Informant Decedent
 Address _____

17. Removal Date thereof Feb. 4, 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory _____
 Location Washington, D.C.

18. Funeral director W. Ernest Jarvis Co
 Address 1432 2nd St NW

19. Feb. 4, 1946 Rowland S. Phillips
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 4 19 46 at 5:50 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1/11 19 46, to 2/4 19 46, and that I last saw ex alive on 2/4 19 46.

Immediate cause of death Pulmonary tuberculosis DURATION 6 mo.

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Daniel Leo Pinecone M.D. M. D. or otherAddress Glenn Dale, Md. Date signed 2/4/46

RECEIVED

FEB 9 1946

BUREAU

Evidence for addition of name
of place where death
occurred is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 10

CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH MAR 4 - 1946
County PRINCE GEORGES COUNTY
City or town Takoma Park
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 MOS.
Hospital, institution, or street address where death occurred:
6624 Poplar Ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MD County PRINCE GEORGES
City or town Takoma Park
(If outside city or town limits, write RURAL and give nearest town)
Street No. 6624 POPULAR AVE
(If rural, give LOCATION)
2(a) If veteran, name war

3. (a) FULL NAME

OVIE LEO KEETON

3. (b) Social Security Number

216-05-2460

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced MARRIED
6. (b) Name of husband or wife MARIE LEOTA
KEETON (HAWES) 6. (c) If alive, give age 33 years
7. Birth date of deceased (mo., day, yr.) DEC 10, 1901
8. AGE: Years 44 Months 2 Days 3 If less than one day
hrs. min.

9. Birthplace WINSLOW, INDIANA
(Town, county, and state)

10. Usual occupation OIL BURNER MECHANIC

11. Industry or business

12. Name CHARLES MARTIN KEETON

13. Birthplace INDIANA

14. Maiden name CEORA BASS

15. Birthplace INDIANA

16. Informant FLOYD G. KEETON

Address 1912 T ST., S.E. D.C.

17. Burial Date thereof Feb 17, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Montgomery Cemetery

Location Oakland City, Indiana.

18. Funeral director J. Edgar D. Dwyer

Address 254 Carroll St. Takoma Park, D.C.

19. Feb 14, 1946 James Sever

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 13, 1946, at 4:40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Feb 8, 1946, to Feb 13, 1946
and that I last saw him alive on Feb 13, 1946

Immediate cause of death Sepsis pneumonia DURATION 5 days

Due to

Due to

Other conditions Intestinal regurgitation

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Wm. A. Shannon M.D.

Address 112 Carroll St. W. Date signed Feb 13, 1946

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

FEB 18 1946

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 35

CERTIFICATE OF DEATH

Reg. Dist. No.

01815

245

1. PLACE OF DEATH:

County Prince GeorgeCity or town Riverdale, Md.
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 1 day 9 1/2 hrs.

Hospital, institution, or street address where death occurred:

Eugene Deland Memorial Hosp RiverdaleHow long in hospital or institution? 1 day 9 1/2 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince GeorgeCity or town Wattsville
(If outside city or town limits, write RURAL and give nearest town)Street No. 6302 20th Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Latimer, Mrs. Charlesetta Kathleen

3. (b) Social Security Number

4. Sex Fe 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed6.(b) Name of husband or wife Edward Lyman Latimer
(deceased) 6.(c) If alive, give age _____ years7. Birth date of deceased (mo., day, yr.) June 20, 18848. AGE: Years 61 Months 1 Days 17 It less than one day _____ hrs. _____ min.9. Birthplace Washington, D.C.
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

12. Name Thomas Hynes13. Birthplace New York14. Maiden name Tessie Morris15. Birthplace New York16. Informant Eugene Deland Memorial HospitalAddress Riverdale, Md.17. Burial Date thereof Feb 20, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Arlington CemeteryLocation Arlington Va18. Funeral director ThrockmorsAddress Wattsville Md19. Feb 19 46 James Seely
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 17, 1946, at 11:02 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 12 1946, to Feb 17 1946, and that I last saw her alive on Feb 17, 1946.

Immediate cause of death

Influenza Pneumonia

DURATION

days

Due to

Due to

Other conditions Chronic Bronchitis
asbestos & arthritis
(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE Thos. Hynes M. D. or otherAddress Wattsville Date signed Feb 17, 1946

RECEIVED

FEB 20 1946

BUREAU V E

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 486

CERTIFICATE OF DEATH

Reg. Dist. No. 1816 245

1. PLACE OF DEATH:

County EdmondsonCity or town Edmondson
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 5 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Pr Geo. CoCity or town Edmondson
(If outside city or town limits, write RURAL and give nearest town)Street No. 5200 Crittenden St
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

Sarah Belle Lutz

3. (b) Social Security Number

4. Sex F 5. Color or race W 6. (a) Single, married, widowed or divorced married8. (b) Name of husband or wife Wm F Lutz8. (c) If alive, give age 45 years7. Birth date of deceased (mo., day, yr.) March 21-19008. AGE: Years 45 Months 0 Days 0 If less than one day hrs. min.9. Birthplace Madison Co. Va
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

12. Name Wm A. Rawlings13. Birthplace Va14. Maiden name Lucy Gossells15. Birthplace Va16. Informant Wm F LutzAddress 5200 Crittenden St. Edmondson, MD17. Burial Date thereof 2/26/46
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Fr. Lin. CemeteryLocation Wash. D.C.18. Funeral director Two Church CoAddress Riverdale, MD19. Jul 24 1946 James Severy
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 24 1946 at MD21. I CERTIFY that death occurred on the date above stated; that I attended deceased from just 1945, to 2-24 1946and that I last saw him alive on 2-24 1946Immediate cause of death carcinoma of uterus

DURATION

3 yrs

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings at operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Iron and HaysAddress Hagerstown, Md M. D. or other 2-28-46

Date aligned

RECEIVED

FEB 28 1946

BUREAU V. R.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13-

CERTIFICATE OF DEATH

Reg. Dist. No.

01817243

1. PLACE OF DEATH:

County Prince George's
 City or town (rural) Glenn Dale, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 3 mos., 19 days
 Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
 How long in hospital or institution? 3 mos., 19 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State D. C. County _____
 City or town Washington
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1324 - 8th St. N. W.
 (If rural, give LOCATION)
 2. (a) If veteran, name war _____

3. (a) FULL NAME

Mildred Mack

3. (b) Social Security Number

-

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

6. (c) If alive, give age _____ years

7. Birth date of

deceased (mo., day, yr.)

December 11, 1921

8. AGE:

Years

Months

Days

If less than one day

2426

_____ hrs. _____ min.

9. Birthplace

Washington, D. C.

(Town, county, and state)

10. Usual occupation

Housekeeper

11. Industry or business

FATHER
MOTHER

12. Name

George H. Mack

13. Birthplace

Edwards, Mississippi

14. Maiden name

Mary Robinson

15. Birthplace

Edwards, Mississippi

16. Informant

Decedent

Address

17.

Removal

Date thereof

2-12-46

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

to Washington, D.C.

Location

18. Funeral director

Mason & Soley

Address

424 R. St. N.W.

19.

Feb. 17, 1946T. Rowland S. Phillips

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Feb. 1719. 46at 4:20 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Oct. 2919. 45to Feb. 17, 1946

and that I last saw him/her alive on

Feb. 17, 1946

Immediate cause of death

Pulmonary tuberculosis

DURATION

4 mos

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Daniel Leo Pinicane M.D.

M. D. or other

Address

Glenn Dale, Md.Date signed 2-17-46

RECEIVED
FEB 25 1946
BUREAU V.B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 136

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH:

County Prince George's
 City or town (rural) Glenn Dale, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 6 mos., 17 days
 Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
 How long in hospital or institution? 6 mos., 17 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State D. C. County _____
 City or town Washington
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 2028 Lawrence St. N. E.
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3.(a) FULL NAME

Joseph J. Mandera

3.(b) Social Security Number

579-05-8441

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Married

8.(b) Name of husband or wife

Anna Blanche Mandera

7. Birth date of

deceased (mo., day, yr.)

April 26, 18846.(c) If alive, give age 64 years

8. AGE:

Years

Months

Days

If less than one day

61925

.....hrs.min.

9. Birthplace Pittsburgh, Pennsylvania

(Town, county, and state)

10. Usual occupation

Painter

11. Industry or business

FATHER

12. Name

Joseph Mandera

13. Birthplace

Pittsburgh, Pennsylvania

14. Maiden name

Caralina Mayo

15. Birthplace

Pittsburgh, Pennsylvania

16. Informant

Decedent

Address

17. Removal to

(Burial, cremation, or removal. Which?)

Date thereof Feb. 21, 1946
(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19. Feb. 21, 1946

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 21 19 46 at 9:05 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

8-3 19 45, to 2-21 19 46and that I last saw him alive on 2-21 19 46

Immediate cause of death

tuberculous bronchopneumonia

DURATION

12 daysDue to pulmonary tuberculosis7 mos.

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Daniel Leo Pinecone MD.

M. D. or other

Address

Glenn Dale Md.Date signed 2/21/46

RECEIVED
MAR 1 1946
GENERAL A. H.

Evidence for change of birth
date of deceased & age is
shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13-1

01819

CERTIFICATE OF DEATH

Reg. Dist. No. 243

FILM No. 100 MAR 5 - 1946

1. PLACE OF DEATH:

County Prince George's
City or town (rural) Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 yr., 9 mos., 13 days
Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
How long in hospital or institution? 1 yr., 9 mos., 13 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State D. C. County _____
City or town Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3207 Cherry Hill, N. W.
(If rural, give LOCATION)
2. (a) If veteran, name war _____

3. (a) FULL NAME

Helen May

3. (b) Social Security Number

4. Sex Female 5. Color or race Colored 6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife Richard May (deceased)

7. Birth date of deceased (mo., day, yr.) May 10, 1889 1900 6. (c) If alive, give age _____ years

8. AGE: Years 45 Months 56 Days 9 13 hrs. min.

9. Birthplace Washington, D. C.
(Town, county, and state)

10. Usual occupation Domestic

11. Industry or business _____

12. Name Charles Jackson
13. Birthplace Virginia

14. Maiden name Georgeanna Jackson (maiden name unknown)
15. Birthplace Virginia

16. Informant Decedent
Address _____

17. Removal to Date thereof Feb. 24, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory _____
Location Washington, D. C.

18. Funeral director W. Ernest Jarvis Co
Address 1432 8th St NW

19. Feb. 23, 1946 Rouland S. Phillips
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 23, 1946 at 8:20 A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 10, 1944 to Feb. 23, 1946
and that I last saw him alive on Feb. 23, 1946

Immediate cause of death Tubercular tuberculosis DURATION 1 yr. 9 mos

Due to _____
Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____
Autopsy results _____
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide _____ Date of _____
Where did injury occur? _____ (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) _____
Means of injury _____ Injured at work? _____

23. SIGNATURE Daniel Leo Pinucane MD M. D. or other _____
Address Glenn Dale, Md. Date signed 2-23-46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAR 1 1946
BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 972

CERTIFICATE OF DEATH

Reg. Dist. No. 01820 232

1. PLACE OF DEATH:

County Prince GeorgeCity or town Muellwood
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED

(For newborn infants give residence of mother)

State Maryland County Prince GeorgesCity or town Muellwood
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Era E. P. Mayhew

3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female white married6. (b) Name of husband or wife James B. Mayhew, Jr.

7. Birth date of

deceased (mo., day, yr.)

6. (c) If alive, give age _____ years

8. AGE:

Years

Months

Days

If less than one day

5255

hrs.

min.

9. Birthplace

Pr. Geo. Co., Md.

(Town, county, and state)

10. Usual occupation

Dr. homes

11. Industry or business

MOTHER FATHER

12. Name

George H. Padgett

13. Birthplace

Pr. Geo. Co., Md.

14. Maiden name

Elizabeth P. Frost

15. Birthplace

Pr. Geo. Co., Md.

16. Informant

Mrs. Gering Warfield

Address

Muellwood, Md.

17. Burial

(Burial, cremation, or removal? Which?)

Date thereof

2-9-46
(month) (day) (year)

Cemetery or crematory

Cedar Hill

Location

Lutland, Md.

18. Funeral director

Peter Brothers

Address

Upper Marlboro, Md.

19. Feb 8 1946

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 6 19 46 at 4:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

August 19 42 to Feb. 6 19 46and that I last saw him alive on Feb. 5 19 46

Immediate cause of death

Cerebral hemorrhage

DURATION

30 hours

Due to

Hypertensive arterio-sclerotic disease5+6 years

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

J. E. M. M. M. D.
Washington, D.C.

M. D. or other

Address Washington, D.C. Date signed 2-7-46

RECEIVED
FEB 9 1946
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH:

County Prince George's
 City or town (rural) Glenn Dale, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 11 mos., 7 days
 Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium, Glenn
 How long in hospital or institution? 11 mos., 7 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State D. C. County _____
 City or town Washington
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1620 Concord Ave., N. W.
 (If rural, give LOCATION)
 2. (a) If veteran, name war. —

3. (a) FULL NAME

MARK S. MCCOY

3. (b) Social Security Number

—

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Gladys McCoy
 6. (c) If alive, give age 39 years
 7. Birth date of deceased (mo., day, yr.) March 16, 1896
 8. AGE: Years 49 Months 10 Days 17 If less than one day _____ hrs. _____ min.

9. Birthplace Red Oak, Iowa
 (Town, county, and state)
 10. Usual occupation Accountant
 11. Industry or business _____
 12. Name James McCoy
 13. Birthplace Illinois
 14. Maiden name Nellie O'Brien
 15. Birthplace Iowa

16. Informant Decedent
 Address _____

17. Burial Date thereof Feb. 3, 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Mt. Olive Cemetery
 Location Washington, D.C.

18. Funeral director Huntman Funeral Home
 Address 5732 Gq Ave N.W.

19. Feb. 2, 1946 Rowland S. Phillips
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 2, 1946 at 9:57 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 26, 1945 to Feb. 2, 1946
 and that I last saw him alive on Feb. 1, 1946

Immediate cause of death Pulmonary Tuberculosis DURATION 1 yr 2 mo

Due to _____
 Due to _____

Other conditions _____
 (Include pregnancy within 3 months of death)

Major findings of operations _____

Autopsy results Pulmonary tuberculosis & cor pulmonale
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____

23. SIGNATURE Daniel Leo Pinucane M.D. M. D. or other _____
 Address Glenn Dale, Md. Date signed 2/2/46

RECEIVED

FEB 9 1946

BUREAU U.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 131-6

CERTIFICATE OF DEATH

Reg. Dist. No. 242

1. PLACE OF DEATH:

County Prince George's
City or town Capitol Heights
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 years
Hospital, institution, or street address where death occurred:
315-48th Street
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Prince George's
City or town Capitol Heights
(If outside city or town limits, write RURAL and give nearest town)
Street No. 315-48th Street
(If rural, give LOCATION)
2(a) If veteran, name war

3. (a) FULL NAME

Margaret Veronica McGray

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed
6. (b) Name of husband or wife Edward M. Gray

7. Birth date of deceased (mo., day, yr.) Aug 15, 1877 6. (c) If alive, give age _____ years

8. AGE: Years 68 Months 6 Days 2 It less than one day _____ hrs. _____ min.

9. Birthplace Penn.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name Francis Heslin

13. Birthplace Ireland

14. Maiden name Isabella Bradley

15. Birthplace Scotland

16. Informant Margaret Thompson

Address 315-48th St, Capitol Heights

17. (Burial, cremation, or removal. Which?) 2-18-46
(month) (day) (year)

Cemetery or crematory St. Patrick Cemetery

Location Harrisstown Pa.

18. Funeral director Wm. Chambers Co.

Address 517-11th St. S.E. Washington D.C.

19. Feb 17 1946 Carrie Campbell
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 17 1946 at 9:50 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from _____ 19_____, to _____ 19_____, and that I last saw him _____ alive on _____ 19_____.

Immediate cause of death acute congestive heart failure
Due to cardiovascular renal disease
Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)

Major findings of operations _____
Date of op. _____

Autopsy results _____
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE James J. Bond
M. D. or officer

Address Harrisstown Pa. Date signed 2-17-46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAR 18 1946
BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

01823

282

1. PLACE OF DEATH:

County Prince GeorgesCity or town Melwood
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 10 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince GeorgesCity or town Melwood
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2. (a) If veteran, name war _____

3. (a) FULL NAME

Childs Welch Mitchell, Childs Welch

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

Era E. Derillbliss

7. Birth date of

deceased (mo., day, yr.) December 25-1870

6. (c) If alive, give age _____ years

8. AGE:

Years 75 Months 1 Days 11 If less than one day _____ hr. _____ min.

9. Birthplace

Upper Marlboro, Prince Georges Co., Md.
(Town, county, and state)

10. Usual occupation

Retired

11. Industry or business

Hendrick G. Mitchell

12. Name

Dr. Geo. Co., Inc.

13. Birthplace

Upper Marlboro, Prince Georges Co., Md.

14. Maiden name

Anna C. Lidge

15. Birthplace

Anne Brunel Co., Md.

16. Informant

Joseph H. Mitchell

Address

Melwood, Md.

17. Burial

Burial Date thereof 3-8-46
(Burial, cremation, or removal (which?) (month) (day) (year))

Cemetery or crematory

Brandy

Location

Upper Marlboro, Md.

18. Funeral director

Fitcher Brothers

Address

Upper Marlboro, Md.

19. Sub 8

2-6-46

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 6, 1946 at 7:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

_____ 19____, to _____ 19____

and that I last saw him _____ alive on _____ 19____

Immediate cause of death

cerebral compressionDue to intracranialhemorrhage

Due to _____

Other conditions _____

Other conditions _____

Other conditions _____

Other conditions _____

Other conditions _____

Other conditions _____

Other conditions _____

Other conditions _____

Other conditions _____

Other conditions _____

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Other conditions _____

Other conditions _____

Other conditions _____

Other conditions _____

Other conditions _____

RECEIVED
FEB 9 1945
BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1212

CERTIFICATE OF DEATH

01824/5
Reg. Diat. No.

1. PLACE OF DEATH:

County Prince Georges
 City or town College Park
 (If outside city or town limits, write RURAL and give nearest town)
 Now long in above place of death? 1 year
 Hospital, institution, or street address where death occurred:
College Avenue
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Prince Georges
 City or town Chesley
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 5713 - 7th Road
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Gladys Conway Nelson

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

8. (b) Name of husband or wife Albert R. Nelson

8. (c) If alive, give age 32 years

7. Birth date of deceased (mo., day, yr.) July 10, 1903

8. AGE: Years 42 Months 7 Days 11 If less than one day
 hrs. min.

9. Birthplace Washington D.C.
 (Town, county, and state)

10. Usual occupation Bookkeeper

11. Industry or business Engineers Research Corp

12. Name Frank Conway

13. Birthplace District of Columbia

14. Maiden name unknown

15. Birthplace

16. Informant Albert R. Nelson

Address Chesley, Md

17. Burial Date thereof Feb 23, 1946

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Cedar Hill

Location Suitland Md

18. Funeral director J. Busch's sons

Address Hyattsville D.C.

19. Feb 20 19 46 James Sevey

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 21 19 46 at 11:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19 to 19

and that I last saw h. alive on 19

Immediate cause of death acute congestive heart failure

Due to cardiovascular renal disease

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work

23. SIGNATURE James Sevey M. D. or other

Address Frederick Md Date signed 2-21-46

RECEIVED

FEB 25 1946

BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01825

Reg. Dist. No.

243

1. PLACE OF DEATH:

County..... Prince George's
 City or town..... (rural) Glenn Dale, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... 5 mos.
 Hospital, institution, or street address where death occurred:
 Glenn Dale Sanatorium
 How long in hospital or institution?..... 5 mos.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... D. C. County.....
 City or town..... Washington
 (If outside city or town limits, write RURAL and give nearest town)
 Street No..... 206 - D. St. N. W.
 (If rural, give LOCATION)
 2.(a) If veteran, name war..... ✓

3. (a) FULL NAME

NIPPER, ALBERT

3. (b) Social Security Number

579-03-8172

4. Sex

Male

5. Color or race

Colored

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife..... Irma Nipper

6. (c) If alive, give age..... ? years

7. Birth date of

deceased (mo., day, yr.) May 12, 1909

8. AGE:

Years

Months

Days

If less than one day

36

8

26

.....hrs.min.

9. Birthplace..... Trenton, South Carolina

(Town, county, and state)

10. Usual occupation.....

Truck Driver

11. Industry or business

FATHER

12. Name..... Ernest Nipper

13. Birthplace..... Trenton, South Carolina

MOTHER

14. Maiden name..... Maggie Scott

15. Birthplace..... Akin, South Carolina

16. Informant..... Decedent

Address

17. Removal

(Burial, cremation, or removal. Which?)

Date thereof.....

2 - 8 - 46

(month) (day) (year)

Cemetery or crematory.....

to Washington, D.C.

Location.....

18. Funeral director.....

Address

19. Feb. 7, 1946

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH.....

Feb. 7, 1946

at 10:00 p. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

9/7

1945

to 2/7

1946

and that I last saw him alive on 2/7 1946

Immediate cause of death.....

pulmonary tuberculosis

DURATION

7 mos.

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?.....

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

Injured at work?

23. SIGNATURE.....

Daniel Leo Pinucane MD

M. D. or other

Address..... Glenn Dale, Md.

Date signed 2/7/46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

FEB 16 1946

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 97

CERTIFICATE OF DEATH



Reg. Dist. No. 01826245

1. PLACE OF DEATH:

County Prince George
City or town Mt. Rainier
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 3417 Otis Street
Stay in hospital or inst. (yrs., or mos., or days) _____
Stay in this community (yrs., or mos., or days) 8. yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Prince Georges
City or town Mt. Rainier
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 3417 - Otis Street
(If rural give LOCATION)

2(e) IF VETERAN, NAME WAR _____

3. (a) FULL NAME

James Monroe Otis

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Nellie Holland Otis

6 (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) Oct. 20, 1873

8. AGE: Years 72 Months _____ Days _____ If less than one day _____ hrs. _____ min.

9. Birthplace Brighton, New York
(Town, county, and state)

10. Usual occupation Builder

11. Industry or business _____

12. Name John Otis

13. Birthplace Grand Isle, Vermont

14. Maiden name Lucretia King

15. Birthplace New York

16. Informant Mrs. Nellie Otis

Address 3417 - Otis St. Mt. Rainier, Md.

17. Burial Date thereof Feb. 2 - 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory _____

Location Springfield, Mass.

18. Funeral director William J. Nalley

Address 3200 - R.I. Ave. Mt. Rainier, Md.

19. Feb. 1, 1946 By James Severe
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 1 1946, at 5:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 12 1943, to Feb. 1 1946, and that I last saw him alive on Jan. 31 1946.

Immediate cause of death _____

Pulmonary Edema - Acute

DURATION

5 mins

Due to

Hypertension
Generalized Arteriosclerosis

5 years

Due to _____

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings: _____

Of operations _____

Of autopsy _____

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work?

23. SIGNATURE Charles C. Hagege M.D.

Address Mt. Rainier, Md. Date signed Feb. 1, 1946

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
FEB 3 1946
BUREAU V.B.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01827242
Reg. Dist. No.

1. PLACE OF DEATH:

County Prince Georges
City or town Seat Pleasant
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 6807 Eads St.
Stay in hospital or inst. (yrs., or mos., or days) _____
Stay in this community (yrs., or mos., or days) 3 1/2 years

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Prince Geo.
City or town Seat Pleasant Ward No. _____
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 6807 Eads St.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR _____

3. (a) FULL NAME

George Nelson Palmer

3. (b) Social Security Number

X

4. Sex Male 5. Color or race White B. (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife _____

6 (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) October 10, 1900

8. AGE: Years 45 Months _____ Days _____ If less than one day _____ hrs. _____ min.

9. Birthplace Washington, D.C.
(Town, county, and state)

10. Usual occupation Carpenter

11. Industry or business House

12. Name Joseph M. Palmer

13. Birthplace Washington, D.C.

14. Maiden name Mary Palmer

15. Birthplace Washington, D.C.

16. Informant Joseph F. Palmer

Address 8807 Eads St. Seat Pleasant

17. Burial Date thereof Feb. 25, 1946

(Burial, cremation, or removal) Which? (month) (day) (year)

Cemetery or crematory Rock Creek

Location Washington, D.C.

18. Funeral director Deaf Funeral Home

Address 4812 Ga. Ave. N.W. Wash. D.C.

19. Feb. 22 19 46 Carrie F. Campbell

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 22 19 46, at 1:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 21 19 46 to February 22 19 46, and that I last saw him alive on February 22 19 46.

Immediate cause of death

Alcoholism

DURATION

10 years

Due to

Myocarditis with congestive heart failure

1 hour
2 days

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE

William Brannin

M. D. Capitol

Address Capitol Date signed 2/24/46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAR 18 1945
BUREAU F.B.I.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH:

County Prince George's
 City or town (rural) Glenn Dale, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 7 mos., 3 days
 Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
 How long in hospital or institution? 7 mos., 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State D. C. County _____
 City or town Washington
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 627 - 2nd St. N. E.
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

JAMES L. PARKER

3. (b) Social Security Number

Lost

4. Sex Male 5. Color or race Colored 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Mary Parker
 7. Birth date of deceased (mo., day, yr.) May 1, 1909 6. (c) If alive, give age ? years
 8. AGE: Years 36 Months 9 Days 21 If less than one day _____ hrs. _____ min.

9. Birthplace Petersburg, Tennessee
 (Town, county, and state)

10. Usual occupation Presser and Cleaner

11. Industry or business

12. Name William Parker

13. Birthplace ?

14. Maiden name Lola Lane

15. Birthplace ?

16. Informant Decedent

Address _____

17. Removal to Date thereof Feb 22, 1946
 (burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory _____

Location Washington, D.C.

18. Funeral director Thos. J. Funeral Service

Address 389-87th Ave. N.W.

19. Feb 22, 1946 Rowland S. Phillips
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH FEBRUARY 22, 1946 at 5:30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from JULY 19, 1945 to FEB. 22, 1946
 and that I last saw him alive on FEB. 22, 1946

Immediate cause of death PULMONARY TUBERCULOSIS DURATION 11 mos.

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

_____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Daniel Leo Pinckney M.D. M. D. or other _____

Address Glenn Dale, Md. Date signed 2/22/46

RECEIVED
MAR 1 1946
BUREAU OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 46-2

CERTIFICATE OF DEATH

01829 243
Reg. Dist. No.

1. PLACE OF DEATH

County Pr. Geo.
City or town Woodmore Mitchellville Md.
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 25 yrs.

3. (a) FULL NAME

Mary Ella Pickeral

3. (b) Social Security Number

4. Sex female 5. Color or race white 6. (a) Single, married, widowed, or divorced widow

6. (b) Name of husband or wife

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) July 11, 1896

8. AGE: Years 49 Months 6 Days 21 It less than one day _____ hrs. _____ min.

9. Birthplace Upper Marlboro Md.
(Town, county, and state)

10. Usual occupation House wife

11. Industry or business

12. Name Joseph Austin Cusick

13. Birthplace unknown

14. Maiden name Georganna Farrell

15. Birthplace Maryland

16. Informant Joseph Austin DeBian
Address Odenton aa co. Md.

17. buried Date thereof Feb 5, 1946.
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Mt Oak.
Location Mitchellville Md.

18. Funeral director Clarence Foreacre

Address Mitchellville Md.

19. Feb 4 19 46 Louise H. Beach
(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State md County Prince Geo.
City or town Mitchellville Ward No. _____
(If outside city or town limits, write RURAL NEAR and give town)

Street No. _____
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR _____

MEDICAL CERTIFICATION

20. DATE OF DEATH February 2 19 46 at 11:45 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar 1 19 45 to Feb. 2 19 46,
and that I last saw him alive on Feb. 2 19 46.

Immediate cause of death

Carcinoma of Stomach

DURATION

1 year

Due to

Due to

Other conditions Arteriosclerosis

PHYSICIAN

Please underline the cause to which death should be charged statistically.

(Include pregnancy within 8 months of death)

Major findings:

Of operations none

Of autopsy no

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE James F. Sargen M. D. or other

Address Upper Marlboro, Md. Date signed 2-2-46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

REC-111
FEB 8 1946
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02069

★ Reg. Diat. No. 242

1. PLACE OF DEATH:

County Prince GeorgesCity or town Fort Foster

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 months

Hospital, institution, or street address where death occurred:

Oxon Hill Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince GeorgesCity or town Fort Foster

(If outside city or town limits, write RURAL and give nearest town)

Street No. Oxon Hill Road

(If rural, give LOCATION)

2(a) If veteran, name war.....

3. (a) FULL NAME

Anthony Mathews Proctor

3. (b) Social Security Number

4. Sex

Male

5. Color or race

Colored

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife.....

7. Birth date of

deceased (mo., day, yr.)

Oct 1, 1945

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

44

.....hrs.min.

9. Birthplace.....

Washington DC

(Town, county, and state)

10. Usual occupation.....

11. Industry or business.....

FATHER

12. Name.....

13. Birthplace.....

MOTHER

14. Maiden name.....

15. Birthplace.....

16. Informant.....

Address

17. Burial

(Burial, cremation, or removal, which?)

Date thereof Feb. 6, 1946

(month) (day) (year)

Cemetery or crematory.....

Location

18. Funeral director.....

Address

19. Feb. 8 -1946

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... Feb 4 1946, at 9:45 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

.....19....., to.....19.....

and that I last saw him.....alive on.....19.....

Immediate cause of death.....

asphyxia

DURATION

Due to.....

smothering in bed

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Accident Date of 2-4-46Where did injury occur? Fort Foster P. G. Me

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?) HomeMeans of injury Smothering in bed Injured at work? No

23. SIGNATURE.....

Address Forestallor Date signed 2-4-46

RECEIVED
MAR 18 1946
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age of birth of deceased is shown on

is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of year of birth of deceased is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *Fig*

CERTIFICATE OF DEATH

Reg. Dist. No. *245*

FILM No. *100* FEB 26 1946

1. PLACE OF DEATH:

County *Prince George's*

City or town *Riversdale Md.*
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? *2 hrs. 40 minutes*

Hospital, institution, or street address where death occurred:

Leland Memorial Hospital

How long in hospital or institution? *2 hrs. 40 minutes*

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Washington* County *D.C.*

City or town *Washington D.C.*
(If outside city or town limits, write RURAL and give nearest town)

Street No. *918 Virginia Ave S.W.*
(If rural, give LOCATION)

2.(a) If veteran, name war *✓*

3. (a) FULL NAME

Mrs. Bernie Pullin

3. (b) Social Security Number

4. Sex *F* 5. Color or race *W* 6.(a) Single, married, widowed, or divorced *Widow*

6.(b) Name of husband or wife *Tyler J. Pullin*

April 2, 1873 6.(c) If alive, give age *73* years

7. Birth date of deceased (mo., day, yr.) *1872*

8. AGE: Years *73* Months *10* Days *9* If less than one day *hrs. min.*

9. Birthplace *Virginia*
(Town, county, and state)

10. Usual occupation *Housewife*

11. Industry or business

12. Name *James Weeks*

13. Birthplace *Virginia*

14. Maiden name *Matilda Luthard*

15. Birthplace *Virginia*

16. Informant *John Pullin (son) 12.6.*

Address *918 Virginia Ave S.W. Wash.*

17. *Removal* Date thereof *FEB-11-46*
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory *Washington, D.C.*

Location *W.A. Chambers &*

19. Funeral director *W.A. Chambers &*

Address *517-11-18 S.E.*

Feb 11 1946 Registrar *James Seery*

(Date rec'd by registrar)

MEDICAL CERTIFICATION

February 11, 1946 (LL)

20. DATE OF DEATH *February 11, 1946* at *10* M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *Feb 11, 1946* to *Feb 11, 1946*

and that I last saw h. *ER* live on *Feb 12, 1946*

Immediate cause of death

Terminal pneumonia & toxemia

Due to *Carcinoma of cervix*

Due to *= distant metastases*

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury injured at work?

23. SIGNATURE

Lawrence J. Williams M. D. or other

Address *4604 Greenbury Rd* Date signed *Feb 11, 1946*

RECORDED
FEB 15 1946
U.S. DEPT. OF JUSTICE

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1822

CERTIFICATE OF DEATH

01831

Reg. Dist. No.

232

1. PLACE OF DEATH:

County Prince Geo. Co
City or town Woodyard Upper Marlboro Md
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 14 years.

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 14 years.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Prince George
City or town Upper Marlboro AFD #1
(If outside city or town limits, write RURAL NEAR and give town)
Ward No. _____

Street No. _____

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR _____

3. (a) FULL NAME

Laura Gladys Pyles

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced widow

6 (b) Name of husband or wife _____

6 (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) Jan 8 1889

8. AGE: Years 57 Months 1 Days 14 hrs. _____ min. _____

9. Birthplace Virginia
(Town, county, and state)

10. Usual occupation House wife

11. Industry or business _____

12. Name John Estes

13. Birthplace Virginia

14. Maiden name Laura Creel

15. Birthplace Virginia

16. Informant John W. Pyles

Address 7507 Fr. St. Seatonsburg Md

17. Buried Date thereof Feb 25 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Belle Cemetery

Location Camp Springs and

18. Funeral director Blanche Hovace

Address Mitchellville Md.

19. Feb 24 1946
(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 22 1946 at 11:45 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 1944 to Feb 22 1946
and that I last saw him alive on Feb 22 1946

Immediate cause of death Coronary Heart Failure
Due to Nephritis

Due to Arteriosclerosis

Other conditions Secondary Anemia

(Include pregnancy within 8 months of death)

Major findings:

Of operations none

Autopsy no

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury car

Injured at work? _____

23. SIGNATURE James P. Sancer

M. D. or other

Address Upper Marlboro Md Date signed 2-22-46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PHYSICIAN
Please underline the cause to which death should be charged statistically.

RECEIVED

FEB 26 1946

BUREAU V S

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 107

CERTIFICATE OF DEATH

Reg. Dist. No. 239

1. PLACE OF DEATH:

County Prince Georges
 City or town Laurel
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 4 years 5 mos 11 days
 Hospital, institution, or street address where death occurred:
Laurel Sanatorium
 How long in hospital or institution? 4 years 5 mos

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Baltimore
 City or town Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 5206 St Georges Ave
 (If rural, give LOCATION)
 2(a) If veteran, name war ✓

3. (a) FULL NAME

LUCY HOOPER ROBINSON

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed
 6. (b) Name of husband or wife Wm P. Robinson
 7. Birth date of deceased (mo., day, yr.) Dec-20-1866 8. (c) If alive, give age _____ years
 8. AGE: Years 79 Months 1 Days 21 It less than one day _____ hrs. _____ min.

9. Birthplace Baltimore, Md.
 (Town, county, and state)

10. Usual occupation None

11. Industry or business none

12. Name Robinson W. Cator

13. Birthplace Md

14. Maiden name Mary C. Pattison

15. Birthplace Md

16. Informant son R. Cator Robinson

Address 4000 Cathedral Ave, Wash DC

17. Burial Date thereof 2-14-46
 (Burial, cremation, or removal, which?) (month) (day) (year)

Cemetery or crematory Greenmount

Location Baltimore

18. Funeral director Stewart M. Mink

Address 108 W. M. Ave.

19. 2-13-46 Registrar James

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH February 11 19 46 at 11:35 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 31 19 41 to Feb 11 19 46

and that I last saw him alive on February 11 19 46

Immediate cause of death Bronchopneumonia

in (Primary) Arterio-sclerosis

Due to Senility

Other conditions _____

Major findings of operations _____

(Include pregnancy within 3 months of death)

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE J. C. Poggins M. D. or other _____

Address Laurel Date signed 12-7-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (6)

CERTIFICATE OF DEATH

Reg. Dist. No. 01833 245

1. PLACE OF DEATH:

County Prince Georges

City or town Riverdale Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 days

Hospital, institution, or street address where death occurred

Beland Memorial Hospital

Now long in hospital or institution? 4 day 3 1/2 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Wash. D. C., County

City or town D. C.
(If outside city or town limits, write RURAL and give nearest town)Street No. 441-7th St S.W.
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

A. Abraham Rosenberg

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed

8. (b) Name of husband or wife

Fannie Rosenberg

Deceased

6. (c) If alive, give age years

7. Birth date of

deceased (mo., day, yr.)

March 11, 1878

8. AGE:

Years

Months

Days

If less than one day

67

10

25

hrs.

min.

9. Birthplace

Lithuania, Europe
(Town, county, and state)

10. Usual occupation

Retired

11. Industry or business

Shoe Business

FATHER

12. Name

Jacob Rosenberg

MOTHER

13. Birthplace

Lithuania, Europe

14. Maiden name

Marion Goldberg

15. Birthplace

Lithuania, Europe

16. Informant

Hospital Records

Address

Beland Memorial Hosp. Riverdale, Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

Feb 8 1946
(month) (day) (year)

Cemetery or crematory

Adas Israel C.

Location

Washington D.C.

18. Funeral director

B. Danzansky & Son

Address

3501-14th St N.W.

19. Feb. 5

(Date rec'd by registrar)

1946 James Severs

(Registrar)

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 5 1946 at 5:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb 1, 1946 1946 to Feb 5 1946

and that I last saw him alive on Jan 27 1946

Immediate cause of death

DURATION

Pulmonary Edema

Due to Hypertensive Heart

Disease

Due to Diabetes

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations none

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Rowland F. Wilkinson M.D.

Address 4404 Queensbury Rd Riverdale Md Date signed 2/5/46

RECEIVED
FEB 12 1946
BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 123-6

CERTIFICATE OF DEATH

Reg. Dist. No. 242

1. PLACE OF DEATH:

County Prince George's
 City or town Suitland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 1 year
 Hospital institution, or street address where death occurred:
Suitland Hall
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Prince George's
 City or town Suitland
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Suitland Hall
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3.(a) FULL NAME

Angelina Ann Scharmer

3.(b) Social Security Number

4. Sex

Female

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Single

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

Feb 16, 1924

6.(c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

21116

hrs.

min.

9. Birthplace

(Town, county, and state)

10. Usual occupation

Specialist 3C

11. Industry or business

U.S. Navy

MOTHER

12. Name

Unknown

13. Birthplace

Unknown

14. Maiden name

Unknown

15. Birthplace

Unknown

16. Informant

U.S. Navy Record

Address

Wash. D.C.

17. (Burial, cremation, or removal. Which?)

Removal

Date thereof

2-2-46
(month) (day) (year)

Cemetery or crematory

Location

Naval Dispensary Wash

18. Funeral director

Address

19.

(Date rec'd by registrar)

19

46Phos. D. Scharmer
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

February 2, 1946, at 12:10 A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19 to 19

and that I last saw him alive on 19

Immediate cause of death

acute cyanide poisoning

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide homicide Date of 2-2-46Where did injury occur? Suitland PG (City or town) MD (County) MD (State)

Injured at home, farm, industry, public place (where?)

Means of injury Drunk bullet Injured by gun

23. SIGNATURE

James H. I. Smith
Forestville MD
M.D. or other

Address

Date signed 2-2-46

UNITED STATES DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED
FEB 19 1946
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 01835 242

1. PLACE OF DEATH:

County Prince Georges Forestville, Md.
 City or town (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yearHospital, institution, or street address where death occurred:
5398-3rd Ave. AS

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince Georges
 City or town Forestville, Md.
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 5398-3rd Ave
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Margaret M. Seaman

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife William

7. Birth date of deceased (mo., day, yr.) June 11th 1872 6. (c) If alive, give age..... years

8. AGE: Years 73 Months 8 Days 13 If less than one day..... hrs. min.

9. Birthplace New York
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name Patrick Markey
Ireland

13. Birthplace

14. Maiden name Mary McKenzie

15. Birthplace Scotland

16. Informant Mrs Harriet Morris

Address 5398-3rd Ave Forestville, Md.

17. (Burial, cremation, or removal, which?) burial Date thereof Feb 24, 1946
 (month) (day) (year)

Cemetery or crematory Staten Island, N.Y.

Location

18. Funeral director The S. H. Hines Co

Address 2901-14 - st N.W. Wash. D.C.

19. 2-24-46 19 46 Thos. J. Lippich
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

2D. DATE OF DEATH Feb 24 19 46 at 1:00 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 20 19 46 to Feb 24 19 46
 and that I last saw him alive on Feb 23 19 46

Immediate cause of death uremia
 Due to Coronary occlusion
 Due to Cardiovascular renal disease
 Other conditions.....
 (Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.

Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE James J. Bond M. D. or other Forestville, Md.
 Address Date signed 2-24-46

RECEIVED
FEB 28 1946
BUREAU V. A.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 2405

1. PLACE OF DEATH:

County..... Pro Geo County
 City or town..... Hyattsville Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... 24 years
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State..... Maryland County..... Pro Geo Co
 City or town..... Hyattsville Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 Street No..... 5021 Edmonston Road
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Bessie Self

3. (b) Social Security Number

4. Sex <u>female</u>	5. Color or race <u>white</u>	6.(a) Single, married, widowed, or divorced <u>married</u>
-------------------------	----------------------------------	---

6.(b) Name of husband or wife..... Geo F. Self.
 6.(c) If alive, give age..... years
 7. Birth date of deceased (mo., day, yr.)..... Nov 19, 1894
 8. AGE: Years Months Days If less than one day
52 hrs. min.

9. Birthplace..... Washington D. C.
 (Town, county, and state)
 10. Usual occupation..... Housewife
 11. Industry or business
 12. Name..... Julius Thomas
 13. Birthplace..... Washington D. C.
 14. Maiden name..... Eva Campbell
 15. Birthplace..... Washington D. C.

16. Informant..... George F. Self
 Address..... Hyattsville Maryland.
 17. Burial..... Feb 19, 1946
 (Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)
 Cemetery or crematory..... Ft. Lincoln
 Location..... Colmar Manor Md.
 18. Funeral director..... F. Gasch's Sons
 Address..... Hyattsville Maryland.

19. Feb 18 19 46 James Cleary
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

Feb 16, 1946

20. DATE OF DEATH..... 19..... 21.....

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
April 26 1945 to Feb 16 1946
 and that I last saw h..... alive on Feb 16 1946

Immediate cause of death..... Car Anomoloses
 DURATION..... 6 months
 Due to..... Aggravated Cell Coloma
off vagina with
attention to action
metastasis to liver
presenting glands etc
 Other conditions.....

(Include pregnancy within 8 months of death)
 Major findings of operations..... Car Anoma of pelvis
has Date of op. Oct 25/45

Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....
 Where did injury occur?..... (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury..... Injured at work?

23. SIGNATURE..... Robert R. Hattel MD
 Address..... 1222 Monroe St M. D. or other
MD Date signed..... 2/27/46

RECEIVED

FEB 20 1946

BUREAU V L

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01837

Reg. Dist. No. 231

1. PLACE OF DEATH:

County Prince George's
City or town Fairmont Heights
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death: Permanent
Hospital, institution, or street address where death occurred:
Foster Street near 61st

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State District of Columbia
City or town Leesville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 5011 Nye Place NE
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Roosevelt Shepherd

3. (b) Social Security Number

4. Sex

male

5. Color or race

Colored

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

Nov. 6, 1927

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

18

2

25

hrs.

min.

9. Birthplace

District of Columbia

(Town, county, and state)

10. Usual occupation

Soldier

11. Industry or business

U. S. Army

FATHER

12. Name

Lawrence Shepherd

13. Birthplace

South Carolina

MOTHER

14. Maiden name

Mary Adair

15. Birthplace

South Carolina

16. Informant

Mrs Mary Shepherd

Address

5011 Nye Place NE

17. Removal

(Burial, cremation, or removal. Which?)

Washington General Home

Cemetery or crematory

Washington DC

Location

18. Funeral director

F. Ricketts sons

Address

Hyattsville Md.

19.

(Date rec'd by registrar)

19

46

Branda Doney

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

February 17 1946 at 12:30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19..... 10..... 19.....

and that I last saw him..... alive on..... 19.....

Immediate cause of death

Hemorrhage
Shock
Crushed skull

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of 2-17-46

Where did injury occur? Fairmont Heights P. D. Md.
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Foster Street

Means of Injury Pedestrian struck by car

Physician medical Examiner

23. SIGNATURE James D. Boyd
M. D. or other

Address: 70 Westville Rd Date signed 2-17-46

UNITED STATES DEPARTMENT OF JUSTICE

OFFICE OF THE ATTORNEY GENERAL

WASHINGTON, D. C. 20530

MEMORANDUM

TO : THE ATTORNEY GENERAL

FROM : [illegible]

SUBJECT : [illegible]

DATE : [illegible]

RECEIVED

FEB 21 1946

BUREAU OF

RECEIVED FEB 21 1946

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11838

Reg. Dist. No.

245

1. PLACE OF DEATH:

County Prince George'sCity or town Hyattsville
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 3 hrs.

Hospital, institution, or street address where death occurred:

Selands Mem. Hosp.How long in hospital or institution? 3 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State D.C. County WashingtonCity or town Washington
(If outside city or town limits, write RURAL and give nearest town)Street No. 1943 NEW YORK AVE NE
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

ERNEST SAMUEL SMITH

3. (b) Social Security Number

229-07-1410

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

June 16, 1905

6. (c) If alive, give age years

8. AGE:

Years 40 Months 8 Days 1 If less than one day
hrs. min.

9. Birthplace

Lexington Va.
(Town, county, and state)

10. Usual occupation

Mechanic

11. Industry or business

Wash. Paper Co.

FATHER

MOTHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

17. (Burial, cremation, or removal. Which?)

18. Funeral director

19. (Date rec'd by registrar)

20. DATE OF DEATH

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

22. VIOLENCE: If death was due to external causes, fill in the following:

23. SIGNATURE

24. Address

25. Date signed

26. Registrar

27. Date signed

28. Date signed

29. Date signed

30. Date signed

31. Date signed

32. Date signed

33. Date signed

34. Date signed

35. Date signed

36. Date signed

37. Date signed

38. Date signed

39. Date signed

40. Date signed

41. Date signed

42. Date signed

43. Date signed

44. Date signed

45. Date signed

46. Date signed

47. Date signed

48. Date signed

49. Date signed

50. Date signed

51. Date signed

52. Date signed

53. Date signed

54. Date signed

55. Date signed

56. Date signed

57. Date signed

58. Date signed

59. Date signed

60. Date signed

61. Date signed

62. Date signed

63. Date signed

64. Date signed

65. Date signed

66. Date signed

67. Date signed

68. Date signed

69. Date signed

70. Date signed

71. Date signed

72. Date signed

73. Date signed

74. Date signed

75. Date signed

76. Date signed

77. Date signed

78. Date signed

79. Date signed

80. Date signed

81. Date signed

82. Date signed

83. Date signed

84. Date signed

85. Date signed

86. Date signed

87. Date signed

88. Date signed

89. Date signed

90. Date signed

91. Date signed

92. Date signed

93. Date signed

94. Date signed

95. Date signed

96. Date signed

97. Date signed

98. Date signed

99. Date signed

100. Date signed

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 17 19 46 at 10:22 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19 to 19

and that I last saw him alive on 19

Immediate cause of death

Pericarditis and shock
Crushed chest

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of 2-17-46Where did injury occur? Berwyn P. g. Ind
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) Home #1Means of injury Electric shock by power line23. SIGNATURE James Severy M. D. or otherAddress Hyattsville Md Date signed 2-18-46

For Dist. No.

ASST

032A

UNITED STATES DEPARTMENT OF JUSTICE

UNIT

(Social Security Number)

LOCATION

10

First 10 digits of Social Security Number

10

10

10

10

(date)

should be changed

the following

date of

injured at work

M. D. or other

RECEIVED
FEB 20 1946
BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 61

CERTIFICATE OF DEATH

01839

Reg. Dist. No. 245

1. PLACE OF DEATH:

County... Prince Georges

City or town... Riverdale, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 26 days

Hospital, institution, or street address where death occurred:

Seland Memorial Hospital

How long in hospital or institution? 26 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Wash DC County...

City or town... Wash DC.
(If outside city or town limits, write RURAL and give nearest town)Street No. 2610 5th St. S.W. Wash DC
(If rural, give LOCATION)

2.(a) If veteran, name war...

3. (a) FULL NAME

Mr Rodney Newman Smith

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

June 25, 1876

6. (c) If alive, give age... years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

69

7

19

hrs.

min.

9. Birthplace... Shapensburg, Md. Washington DC

(Town, county, and state)

10. Usual occupation...

Coal Merchant

11. Industry or business

MOTHER FATHER

12. Name...

David Smith

13. Birthplace

Baltimore, Md.

14. Maiden name

Elizabeth Newman

15. Birthplace

Baltimore, Md.

16. Informant

Hospital Record

Address

17. Removal
(Burial, cremation, or removal. Which?)

Date thereof

Feb 18, 1946
(month) (day) (year)

Cemetery or crematory

436-7th St S.W.

Location

Washington DC.

18. Funeral director

Peter H. Taltavull

Address

436-7th St. S.W. Washington DC.
Feb 28 46 James Seery
(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... February 28 1946 at 3 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb 3 1946 to Feb 28 1946

and that I last saw him alive on Feb 27 1946

Immediate cause of death

Uremia

DURATION

Due to

Cirrhosis of liver
liver failure

Due to

Other conditions

Diabetes mellitus

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Beverland F. Wickham MD
Seland Memorial Hosp
Riverdale Md
Date signed Feb 28, 1946

RECEIVED
MAR 2 1946
BUREAU V R

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore B2

CERTIFICATE OF DEATH

Reg. Dist. No. 02066 243

1. PLACE OF DEATH:

County Prince George's
 City or town (rural) Glenn Dale, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 18 days
 Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
 How long in hospital or institution? 18 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State D. C. County _____
 City or town Washington
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 726 - 11th St. S. E.
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married
 6.(b) Name of husband or wife Emma Soper
 6.(c) If alive, give age 47 years
 7. Birth date of deceased (mo., day, yr.) April 18, 1902
 8. AGE: Years 43 Months 10 Days 5 If less than one day _____ hrs. _____ min.

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 23 1946, at 7:50 A. M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 5, 1946, to Feb. 23, 1946, and that I last saw him alive on Feb. 23, 1946.

Immediate cause of death Tuberculosis DURATION 1 yr. 10 mos.
 Due to Tuberculosis longitidis 2 1/2 mos.
 Due to Tuberculosis eulitidis 18 da.
 Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work?

23. SIGNATURE Daniel Leo Pinicane MD M. D. or other _____
 Address Glenn Dale Md Date signed 2-23-46

9. Birthplace Camp Springs, Maryland
 (Town, county, and state)
 10. Usual occupation Truck Driver
 11. Industry or business _____
 FATHER 12. Name Charles E. Soper
 13. Birthplace Camp Springs, Maryland
 MOTHER 14. Maiden name Jessie Soper
 15. Birthplace Camp Springs, Maryland
 16. Informant Decedent
 Address _____
 17. Burial Date thereof Feb. 23, 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Cedar Hill Cemetery
Prince George's Co., Md.
 Location _____
 18. Funeral director James E. Ryan, Inc.
 Address 317 Penna. Ave. S. E.
 19. Feb. 23, 1946 Rowland S. Phillips
 (Date rec'd by registrar) Registrar

RECEIVED
MAR 1 1946
BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change in
age is shown on

FILM No. I.O 4 MAY 28 1946

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 97

CERTIFICATE OF DEATH

01840

Reg. Dist. No. 242

1. PLACE OF DEATH:

County Prince Georges

City or town Bradbury Heights
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 months

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Pr. Geo.

City or town Bradbury Heights
(If outside city or town limits, write RURAL and give nearest town)

Street No. 5111 Nee S.E. DC. 20
(If rural, give LOCATION)

2(a) If veteran, name war

3. (a) FULL NAME

Warner Stutter

3. (b) Social Security Number

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife Catherine Bee Stutter

7. Birth date of deceased (mo., day, yr.) Aug. 19 1859 8. (c) If alive, give age — years

8. AGE: Years 86 Months 87 Days 5 If less than one day 17 hrs. — min.

9. Birthplace Morganville, Dodgebridge W. Va.
(Town, county, and state)

10. Usual occupation Contractor

11. Industry or business Refining of Oil

12. Name Isaac Stutter

13. Birthplace Unknown

14. Maiden name Babara A. Moore

15. Birthplace Not known

16. Informant D.C. Stutter

Address 5111 Nee - Washington 20 D.C.

17. (Burial, cremation, or removal, Which?) Feb 8 1946
(month) (day) (year)

Cemetery or crematory Cedar Hill Cemetery

Location

18. Funeral director Joseph F. Bueche & Son

Address 3034 - M St. N.W. Wash. D.C.

19. 2-6- 46 Thos D. Griffith
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-5-6- 1946 at 4:10 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 1941 to Feb 5- 1946

and that I last saw him alive on Jan. 27th 1946

Immediate cause of death atherosclerosis

DURATION

5 yrs.

Bue to Natural condition of age

Due to

Other conditions Mal nutrition Indefinite

(Include pregnancy within 3 months of death)

Major findings of operations —

Date of op.

Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Arthur M. Meloy M.D. M.D. or other

Address 4400 Bowen Rd D.C. Date signed 2-6-46

RECEIVED
MAR 18 1946
BUREAU V.B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH:

County Pr. Geo. Co
 City or town Chesley, Md
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Pr. Geo
 City or town Chesley
 (If outside city or town limits, write RURAL and give nearest town)

Street 3018 Lake Ave
 (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Elizabeth Marie Terrell

3.(b) Social Security Number

4. Sex F 5. Color or race W 6.(a) Single, married, widowed, or divorced married6.(b) Name of husband or wife Aubrey H. Terrell

6.(c) If alive, give age.....years

7. Birth date of deceased (mo., day, yr.) Mar. 13 - 19118. AGE: Years 34 Months Days If less than one day9. Birthplace Nanticoke, Pa
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

12. Name John M. Lazas
13. Birthplace Austria14. Maiden name Anna Wargo
15. Birthplace Charfield, Pa16. Informant Anna Lazas, mother
Address 3018 Lake Ave. Chesley, Md17. Buried Date thereof 3-2-46
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory St. Oliver CemeteryLocation Wash. D.C.18. Funeral director W.W. Chambers & CoAddress 577 - 11th St.19. 2/28 19. 46 Amanda Doney
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 28 19. 46 at 3:55 a21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 14 19. 46 to Feb. 28 19. 46 and that I last saw her alive on Feb. 25 19. 46

Immediate cause of death

DURATION

Pulmonary Tuberculosis

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

John D. Maloney M.D.
Address Chesley-Hyattsville Date signed 2-28-46

RECEIVED
MAR 2 1946
BUREAU V. E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (22)

CERTIFICATE OF DEATH

01842

Reg. Dist. No. 231

1. PLACE OF DEATH:

County Prince George

City or town Chantilly, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 12 hours

Hospital, institution, or street address where death occurred:

How long in hospital or institution? 12 hours

3. (a) FULL NAME

Kuzick Mr. Glenn

4. Sex m 5. Color or race W 6. (a) Single, married, widowed, or divorced married

6. (b) Name of husband or wife Kuzick Mrs. Ruth

7. Birth date of deceased (mo., day, yr.) Sept. 2, 1904
6. (c) If alive, give age years

8. AGE: Years 42 Months 0 Days 0 If less than one day hrs. min.

9. Birthplace Ill. (Town, county, and state)

10. Usual occupation Portrait Photographer

11. Industry or business

12. Name Kuzick Mr. Glenn

13. Birthplace Ill.

14. Maiden name Brown, Effie

15. Birthplace Ill.

16. Informant Kuzick Mrs. Ruth

Address 1212-6th St. S.W. - Wash. D.C.

17. Burial Date thereof Nov 5 46
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Arlington Park

Location Arlington, Va.

18. Funeral director W.W. Chambers Co.

Address 517 11th St. S.E.

19. 2/28 46 Amanda Downey
(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State District of Columbia County

City or town Washington
(If outside city or town limits, write RURAL and give nearest town)Street No. 1212-6th St. S.W.
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 28 1946, at 7:55 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

2-27 1946 to 2-28 1946
and that I last saw h.l.m. alive on 2-28 1946

Immediate cause of death

Cardiac decompensation

Due to Rheumatic endocarditis
and mitral stenosis

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results Same

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John J. Maloney, MD

Address Chevy Chase, Hyattsville, Md. or other
Date signed 2-28-46

UNITED STATES DEPARTMENT OF JUSTICE

STANDARD FORM NO. 64

REC'D

MAR 5 1948

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01843

Reg. Dist. No.

245

1. PLACE OF DEATH:

County Prince GeorgeCity or town Riverdale
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 2 days

Hospital, institution, or street address where death occurred:

Leland Memorial HospitalHow long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State A. C. Md. County Prince GeorgeCity or town Riverdale
(If outside city or town limits, write RURAL and give nearest town)Street No. 6209 61st Place
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

Van Fleet, Mrs. Rita Dorothea

3. (b) Social Security Number

4. Sex

Fem.

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

Alvin Oscar Van Fleet (deceased)

7. Birth date of deceased (mo., day, yr.)

Aug. 23, 1870

8. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

7582

hrs.

min.

9. Birthplace

Washington D.C.
(Town, county, and state)

10. Usual occupation

House Keeper

11. Industry or business

FATHER

12. Name

James Byrne

13. Birthplace

Dublin, Ireland

MOTHER

14. Maiden name

Margaret Carney

15. Birthplace

Ireland

16. Informant

Ignatius J. Byrne

Address

17.

(Burial, cremation, or removal. Which?)

Date thereof

Feb 25th 1946
(month) (day) (year)

Cemetery or crematory

Fort Lincoln Cemetery

Location

Wash. D.C. Prince Georges Co. Md.

18. Funeral director

W. W. Chambers Co.

Address

Riverdale Md

19.

(Date rec'd by registrar)

19.

Feb 22nd 46. James Sever

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Feb 21

19

46

at

7²⁰

M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb 20

19

46

to

Feb 21

19

46

and that I last saw h.

ER. alive on

Feb 21

19

46

Immediate cause of death

Peritonitis & toxemia

DURATION

Due to

Intestinal obstruction

Due to

Strangulated Femoral Hernia

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Peritonitis, strangulated bowel
no rt fem. vessel

Date of op.

Feb 20, 1946

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Rowland W. Jackson MD

M. D. or other

Address

4408 Greenbury Pl

Date signed

Feb 21, 1946Riverdale Md

RECEIVED

FEB 25 1946

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age of deceased is shown on

Evidence for change of age MARYLAND STATE DEPARTMENT OF HEALTH
of deceased is shown on

2411 N. Charles St., Baltimore (932)

CERTIFICATE OF DEATH

Reg. Dist. No. 242

FILM No. 101 MAR 28 1946

1. PLACE OF DEATH:

County Prince Georges

City or town Cedar Heights
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 40 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD. County Prince Georges

City or town Cedar Heights
(If outside city or town limits, write RURAL and give nearest town)

Street No. 912-64th Ave. NE.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Alice Wallace

3. (b) Social Security Number

4. Sex Female

5. Color or race Colored

6. (a) Single, married, widowed, or divorced married

6. (b) Name of husband or wife Mike Wallace

6. (c) If alive, give age 72 1/2 years

7. Birth date of deceased (mo., day, yr.) Feb. 3 1884

8. AGE: Years 62 Months 11 Days 1 If less than one day hrs. min.

9. Birthplace Prince Georges Md.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name George Stewart

13. Birthplace MD.

14. Maiden name unknown

15. Birthplace MD.

16. Informant Mike Wallace

Address 912-64th Ave. NE.

17. Burial Date thereof Feb 5, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Mt. Olivet

Location Washington D.C.

18. Funeral director J.B. Johnson

Address Cinnaptis

19. Feb 2 19 46 Jane A. Gomer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 1 19 46 at 11:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 7 19 46 to Feb 1 19 46 and that I last saw her alive on Jan 31 19 46

Immediate cause of death Acute Cardiac Dilatation

Due to CORONARY Thrombosis

Due to ARTERIOSCLEROTIC Heart Disease

Other conditions Essential Hypertension

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Robert R. Melsow MD

M. D. or other

Address 4112 Grant St. NE Date signed 2/1/46

RECEIVED
MAR 18 1946
BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct use is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1312

CERTIFICATE OF DEATH

01845

Reg. Dist. No. 245

1. PLACE OF DEATH:

County Prince GeorgesCity or town Brentwood
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 5 yrs.

Hospital, institution, or street address where death occurred:

4004 Allison St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Ind. County Pr. Geo.City or town 4004 Allison St.
(If outside city or town limits, write RURAL and give nearest town)Street No. Brentwood
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

LUCY WARREN

3. (b) Social Security Number

4. Sex

Female

5. Color or race

Colored

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

1859

8. AGE:

Years

Months

Days

If less than one day

86

hrs. min.

9. Birthplace

Richmond Co. Va.
(Town, county, and state)

10. Usual occupation

At home

11. Industry or business

FATHER

12. Name

Edward Warren

13. Birthplace

Va.

MOTHER

14. Maiden name

Susan

15. Birthplace

Va.

16. Informant

Priscilla Mason
Address 4519 - 41st St. Brentwood, Ind.

17. Removal

Removal Date thereof Feb. 1, 1946
(Burial, cremation, or removal, which?) (month) (day) (year)

Cemetery or crematory

Mc Guire Funeral Home

Location

Washington, D.C.

18. Funeral director

F. J. Pasch's Sons
Address Hyattsville, Md.

19.

210 46 Amanda Downey
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 1, 1946 at 6:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on 19....., to 19.....

Immediate cause of death

Acute congestive heart failure

Due to

Cardiovascular renal disease

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of 19.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Date signed

Means of injury

Injured at work

Allegedly no record of same.

23. SIGNATURE

Forester 2-1-46
Address Date signed

RECEIVED

FEB 6 1946

BUREAU V. F.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No.

01846

237

1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal Which?)

Date thereof

(month) (day) (year)

Cemetery or crematorium

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

19.

MEDICAL CERTIFICATION

20. DATE OF DEATH

February 25, 1946, at 11:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov. 25, 1945, to Feb. 23, 1946

and that I last saw her alive on

Nov. 23, 1946

Immediate cause of death

Mitral Regurgitation 3 years

Due to

Chronic Endocarditis 3 yrs

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, till in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

John E. Bowers M.D.

M. D. or other

Address

Brandywine Rd. Date signed 2/25/46

RECEIVED
MAR 5 1945
BUREAU V. E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 131-22

CERTIFICATE OF DEATH

01847

Reg. Dist. No. 272

1. PLACE OF DEATH:

County Prince Georges
 City or town Upper Marlboro
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 52 years
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Prince Georges
 City or town Upper Marlboro
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Zacharias Watson

3. (b) Social Security Number

4. Sex Male 5. Color or race Colored 6.(a) Single, married, widowed, or divorced Widowed
 6.(b) Name of husband or wife Jessie Watson
 7. Birth date of deceased (mo., day, yr.) March 15, 1871
 6.(c) If alive, give age years
 8. AGE: Years 74 Months 10 Days 27 It less than one day hrs. min.

9. Birthplace Upper Marlboro, Md.
 (Town, county, and state)

10. Usual occupation none

11. Industry or business

FATHER 12. Name Thomas Watson

13. Birthplace Maryland

MOTHER 14. Maiden name Jane D. Callaway

15. Birthplace District Columbia

16. Informant Eliza A. Watson

Address Upper Marlboro, Md.

17. Burial Date thereof Feb. 17, 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Union Cemetery

Location Upper Marlboro, Md.

18. Funeral director J.B. Johnson

Address Annapolis, Md.

19. Feb 17 19 46 Rawlins
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 12 19 46 at 9:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19....., to 19.....
 and that I last saw him alive on 19.....

Immediate cause of death Acute Congestive heart failure
 Due to Cardiovascular renal disease
 Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations.....

..... Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, till in the following:

Accident, suicide, or homicide..... Date of 19.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

Upper Medical Center

23. SIGNATURE James F. [illegible] M.D. or other

Address Frederick, Md. Date signed 2-13-46

RECEIVED BY THE DEPARTMENT OF HEALTH

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RECEIVED

FEB 19 1946

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83-3

CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH:

County Prince GeorgeCity or town Int. Rainier
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince GeorgeCity or town Int. Rainier
(If outside city or town limits, write RURAL and give nearest town)Street No. 3101-Perry
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Rosa R. Weser

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

8. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 17th 1866

8. AGE: Years Months Days If less than one day

79 hrs. min.9. Birthplace Washington D.C.
(Town, county, and state)10. Usual occupation Retired Employee11. Industry or business U. S. Govt.12. Name Charles F. Weser13. Birthplace Washington D.C.14. Maiden name Mary Ritzger15. Birthplace Washington D.C.16. Informant Charles F. WeserAddress 3101-Perry St. Int. Rainier Spd.17. Burial Date thereof 2/26/46
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Int. CalvertLocation Washington D.C.18. Funeral director Wm. J. SpalbyAddress 3200-R.I. Ave Int. Rainier Md.19. Feb 25 19 46 James Bevery
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

2D. DATE OF DEATH February 22 19 46, at 11:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

February 22 19 46, to 2/22 19 46and that I last saw him alive on February 22 19 46Immediate cause of death Cerebral accident

DURATION

13 hrsDue to Hypertension andatherosclerosis3 years

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

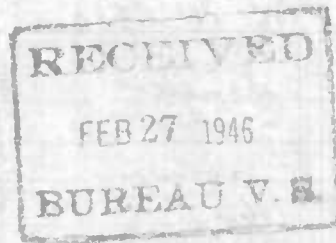
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Charles F. Weser M. D. or otherAddress College Park, Md Date signed 2/25/46

Mr. James I. Boyd was notified 2/22/46
and gave consent for signing of certificate
6 JM



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1142

CERTIFICATE OF DEATH

01849

Reg. Dist. No. 243

1. PLACE OF DEATH:

County Prince George's
 City or town (rural) Glenn Dale, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 3 days
 Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
 How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State D. C. County _____
 City or town Washington
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 212 - 13th St. S. E.
 (If rural, give LOCATION) ✓
 2.(a) If veteran, name war _____

3. (a) FULL NAME

James E. Wheeler

3. (b) Social Security Number

?

4. Sex

Male

5. Color or race

Colored

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

7. Birth date of

deceased (mo., day, yr.)

March 29, 1896

6. (c) If alive, give age _____ years

8. AGE:

Years

Months

Days

If less than one day

491015

hrs.

min.

9. Birthplace

Charles Co., Maryland
(Town, county, and state)

10. Usual occupation

Elevator Operator

11. Industry or business

FATHER

12. Name

George Wheeler

13. Birthplace

Charles Co., Maryland

MOTHER

14. Maiden name

Lulu Wheeler *

15. Birthplace

Charles Co., Maryland

16. Informant

Decedent

Address

17.

(Burial, cremation, or removal. Which?)

Date thereof

Feb. 14, '46
(month) (day) (year)

Cemetery or crematory

Washington

Location

DD. C.

18. Funeral director

Arthur S. Pope

Address

315 - 15th St. SE

19.

Feb. 14, 1946
(Date rec'd by registrar)Rowland S. Phillips
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 14, 1946 at 5:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb. 11, 1946 to Feb. 14, 1946
and that I last saw him alive on Feb. 14, 1946

Immediate cause of death

lung abscess, right 3 wks

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Daniel Leo Pinucane M.D.
M. D. or other

Address

Glenn Dale MdDate signed 2-14-46

RECEIVED

FEB 22 1946

BUREAU OF R

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct use is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01850

CERTIFICATE OF DEATH

Reg. Dist. No.

232

1. PLACE OF DEATH:

County Prince George'sCity or town Clinton Md
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Prince George'sCity or town Clinton Md
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

James Wiseman

3. (b) Social Security Number

4. Sex

male

5. Color or race

colored

6. (a) Single, married, widowed, or divorced

widower
single

6. (b) Name of husband or wife

Nellie Wiseman

7. Birth date of deceased (mo., day, yr.)

Jun. 7 1870

6. (c) If alive, give age _____ years

8. AGE:

Years

76

Months

1

Days

1

If less than one day

hrs.min.

9. Birthplace

Upper Marlboro, Md.
(Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

MOTHER

FATHER

12. Name

Henry Wiseman

13. Birthplace

Prince Geo.

14. Maiden name

Mary Henan

15. Birthplace

Prince George

16. Informant

Beaggin Mason

Address

1201 1/2 St. Annapolis Md

17. Burial, cremation, or removal. Which?

Burial

Date thereat

Feb 19 1946
(month) (day) (year)

Cemetery or crematory

St Johns

Location

Clinton Md

18. Funeral director

J.B. Johnson

Address

Annapolis Md

19. Date rec'd by registrar

Feb 17 1946

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 15 1946, at 11:00 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

_____ 19____, to _____ 19____

and that I last saw him _____ alive on _____ 19____

Immediate cause of death

Acute Congestive heartfailureDue to Cardiovascularrenal disease

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where)? _____

Means of injury _____

Injured at work? _____

Deputy medical Examiner

23. SIGNATURE _____

M.D. or other _____

Address Freshkill Md Date signed 2-16-46

RECEIVED

FEB 19 1946

BUREAU V E

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 46-d

CERTIFICATE OF DEATH

01851

Reg. Dist. No. 245

1. PLACE OF DEATH:
County... Prince George
City or town... Riverdale, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 42 days
Hospital, institution, or street address where death occurred:
Leland Memorial Hosp. Riverdale, Md.
How long in hospital or institution? 42 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State... Washington D.C.
County...
City or town...
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1515 Park Rd. N.W.
(If rural, give LOCATION)
2(a) If veteran, name war...

3. (a) FULL NAME
Mrs. Eula Wisener

3. (b) Social Security Number

4. Sex... F
5. Color or race... W
6. (a) Single, married, widowed, or divorced... Widowed
6. (b) Name of husband or wife... Louis Augustus Wisener
6. (c) If alive, give age... years
7. Birth date of deceased (mo., day, yr.)... July 29, 1871
8. AGE: Years... 74 Months... 5 Days... 13 If less than one day... hrs. min.

9. Birthplace... Washington, D.C.
(Town, county, and state)
10. Usual occupation... housewife
11. Industry or business
12. Name... William D. Sullivan
13. Birthplace... Virginia
14. Maiden name... Mary Farrell
15. Birthplace... Ireland

16. Informant... Hospital Records
Address... Riverdale Maryland
17. Removal... Date thereof Feb 16 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory...
Location... Washington D.C.
18. Funeral director... S. H. Finis Co.
Address... 2901 - 14th St. N.W. Wash. D.C.

19. Date rec'd by registrar... Feb 16 1946
Registrar... James Sever

MEDICAL CERTIFICATION

20. DATE OF DEATH... Feb 16 1946 at 5:08 p.m.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 5 1946 to Feb 16 1946
and that I last saw him alive on Feb 16 1946

Immediate cause of death...
Bronchopneumonia & terminal toxemia
Due to... Coramora of Rectum
Due to... with metastases
Other conditions...
(Include pregnancy within 3 months of death)

Major findings of operations...
Date of op...
Autopsy results...
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide... Date of...
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE... Rowland T. Wickens M.D.
Address... 4408 Greenway Rd. Riverdale Md.
Date signed... Feb 16, 1946

43097 correct

WA. 2516

